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## ORIGINAL ARTICLES.

### *SOME OF THE REASONS WHY THE SURGICAL TREATMENT OF NASAL DISEASE HAS BEEN PLACED ON A CONSERVATIVE BASIS.*

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I HAVE been asked to present to this Society a subject of such broad scope as will interest the general practitioner of medicine. I am convinced that many of the themes and discussions seen on the programs of section meetings would not be suitable here. I feel that this particular subject is in good taste because the general practitioner has done, and is continually doing much to broaden the horizon of the specialist. It need scarcely be said that the physician, who gives his sole attention to the treatment of a very limited portion of the human economy, is greatly hampered by his limitations, and sometimes forgets to take into consideration those broader etiological factors which the general practitioner places at their proper value.

It is very convenient to say here that one of the reasons why surgical operations on the nose and throat have been modified in frequency and in the severity of their character is because of a better appreciation of the fact that no one portion of the human economy can be properly considered a part by itself, independent of its intimate relation with the body as a whole; and consequently local causes of nose and throat disorder, we can safely say, are now overshadowed in importance by etiological influences proceeding from remote organs of the body.

In considering the reasons why nasal operations differ so widely in character from those which were performed in the earlier days, I have been strongly impressed by the fact that the character of the operation was formerly largely determined by the kind of instruments which happened to be devised at that particular time, and it must have been noticed that there has always been a strong inclination to employ a new particular instrument to the exclusion of all others. For example, there was a time ten years ago when many modifications of the old snaring apparatus—some of them very valuable—were added to the outfit of the rhinologist. What was more natural than to employ them? And it was not difficult to believe then that almost every case of moderate nasal obstruction, not of nasal polypi, and not even of true nasal hypertrophy, but the

numerous conditions of simple vascular swelling, were suitable patients for the use of the snare. And so turbinated tissues which were performing a valuable physiological function, both in the front and in the back of the nasal chambers, were encircled by a cold wire and removed. And since this operation required considerable skill, it was a great temptation to physicians practising this specialty to perfect themselves in the use of the snare. It would be wrong to say that the snare alone was to blame for the too frequent removal of the soft tissues overlying the turbinated bones, for we know that rhinologists at that time were frequently in error in believing that these swellings were true connective tissue hypertrophies, instead of, as we now know them frequently to be, temporary vascular swellings and not the primary disorder, but due to other and more important pathologic conditions. The perfection of the galvanocautery also furnished the temptation to frequently destroy tissue when it would have been wiser to have acted in a more conservative manner. Drills and trephines, too, were used frequently, because apparently it was felt that these instruments would not have been devised unless the necessity for their use existed. Many of us remember when these instruments were invented. I recall the first electric storage apparatus—a French importation called "Trouvé's accumulator"—which was used in this country. The nasal and throat electrodes were crude in 1878 and 1879, but they were so much more attractive than any of the means of treating nasal disease which were then in the possession of the nose and throat specialist that the crudeness and unreliability of the newer instruments did not weigh much against them. It will be remembered that before this, that is, before the time of cocaine, of electrical mechanism, of spraying apparatus, and of oily medications, the physician was vainly endeavoring to astringe nasal erectile tissues with harsh solutions of silver, copper and zinc. If, with the invention of better nasal instruments, the rhinologist was tempted to use them with too little discretion it is not difficult to excuse his fault. The injudicious and unskilful use of these instruments injured for a long time the reputation of specialists in diseases of the nose and throat; not alone or so much because the leading specialists used too little discretion in their selection of cases for operation, as that semi-specialists all over the country were operating in a most careless manner. Men who had studied this specialty but a few weeks felt themselves competent to undertake any operative procedure on the nose and throat. The foremost specialists were not blameless, because they

<sup>1</sup> Read before the New York County Medical Society, March 26, 1900.

were the instructors of the medical public and would-be specialists, both at their clinics and in their published writings. And since they freely demonstrated at their clinics the use of snare, cautery, and drill, their example was followed throughout the country. More conservative opinions are now practised and held by the specialists in the large cities, and the beneficial result can be noted in the more reasonable application of surgical measures to nasal disease. The infatuation, also, to become specialists in any one of the many departments of medicine and surgery after a preparation of only six weeks seems to be rapidly waning. And we are reaching a period of medical study where the necessity of a thorough understanding of all that should be known pertaining to a specialty is keenly appreciated.

Another reason why operations were performed too frequently and with less preparation in this rather than in other specialties was that the nasal cavities, in their anterior part, at least, could be so much more easily reached than other mucus-lined cavities. This was proven by the fact that the specialist in the first years of his practice devoted his entire surgical work to the most anterior portion of the nostrils. We know now that usually those anterior swellings were reflex in character, but temporary congestions, and that the real source of irritation was at that time undiscovered and unknown.

We cannot in a paper of this character enter too much in detail into the pathology and etiology of the various forms of nasal disturbance which produce obstruction and disordered function, but we shall perhaps interest you when we say that a large proportion of those cases of nasal swelling which were formerly supposed to be characteristic of so-called hypertrophic rhinitis, and which were always thought to demand operation, are due to irritation arising from some other part of the nasal chambers, or are, in many instances, the exhibition of an active or passive hyperemia caused by temporary or permanent disease of organs in portions of the body quite distant. The general practitioner has aided the specialist in keeping before him the intimate relation between disturbances in the nasal circulation and cardiac, pulmonary, hepatic, and renal disorders. It is difficult for the rhinologist to determine how largely a congestive swelling in the nose is due to local causes and how much to influences remote from the respiratory tract, but it should be our constant study to determine the exact value of each of the many etiological factors. It was difficult, and before the time of cocaine almost impossible, to detect the presence of inflammatory conditions, nervous derangements, and hidden growths in the most inaccessible portions of the nasal chambers and nasal sinuses, and to trace their effect upon the easily observed swellings which were formerly supposed to be the disease itself and not, as is now known, only one of the external manifestations of the hidden trouble. For example, a nostril is examined and found to be very thoroughly occluded by swelling

of all the anterior tissues, both on the turbinated and septal side; the man of limited experience needs no stronger temptation than this appearance to use snare, knife, cautery or acid. But there are many conditions behind such anterior obstruction which could easily be the cause of it, such as a foreign body, a nasal polyp, an enlarged middle turbinated bone, a septal deviation crowded against the opposite side, a catarrhal or suppurative inflammation of either the antral or ethmoidal cavities or of both, a hidden ulceration, a new growth, posterior hypertrophies, postnasal lymphoid enlargements, a local manifestation of a general hyperemia or edema, a localized exhibition of a general vasomotor derangement, not to mention numerous other abnormalities. I beg you to believe that the presence alone of swollen nasal tissue is not sufficient evidence to arrive at the true character and location of nasal disease.

The rhinologist has, we believe, arrived at the point where he is able to determine which one of many irritating factors is the most important cause of the disease, or, recognizing the presence of several disordered conditions, can give to each its proper value, and determine their relations to each other. Surgical work is now constantly performed in the nasal chambers, and when skilfully done should always result to the benefit of the patient. It is due to the rhinologist to explain one or two points which often seem to be forgotten; and one is that such forms of nasal treatment as the application of the galvanocautery and of acid to the hypertrophied tissue are not as troublesome to the patient as the old methods of treatment, when strong solutions of silver, copper, or zinc were sprayed into the nostrils. The coryzas produced by these solutions were most distressing, and very frequently produced acute inflammation of the ears, pharynx, larynx, and bronchial tubes. The destruction and removal of hypertrophies and diseased tissue when properly performed and when the wound is properly protected do not cause enough disturbance to prevent a person from pursuing his usual business.

Much of the bad reputation which formerly clung to nasal operators and operations was due to the distressing constitutional disturbances due to septic absorption which often followed surgical work in the nose. We are able now pretty thoroughly to guard against such infection, so that we do not now as formerly, see sensational reports of cases in the daily press in which a person nearly died from a supposed simple nasal operation. The reputation of nasal surgery has been greatly improved by the greater cleanliness obtained before operation through the use of some one of the formaldehyde preparations, both to disinfect the mucous surfaces and to render the instruments aseptic, and by the protection of the wound with an efficient germicide. And we must not forget to say also that now that the etiology of nasal disease is better understood, operations are less frequent and a smaller amount of tissue is sacrificed. Again, nasal surgery has lately become more conservative because it is but



recently that rhinologists have fully appreciated the intimate relation between a number of general constitutional diseases and certain pathological conditions in the nose and throat. It was found that these conditions did not yield to the most approved medical and surgical measures, and it was appreciated at length that they were manifestations of perhaps gastric, intestinal or hepatic disease or of gout, rheumatism, eczema, or some other constitutional disorder. And, further, it was satisfactorily noted that with proper constitutional treatment of these ailments the nasal swellings disappeared without surgical removal. Aside from the history of the case it is now usual to make the diagnosis of gouty and rheumatic congestion and swelling in the nose and throat by their general character and color.

We should feel that this paper furnished sufficient reason for its presentation to you, if it stated but this one proposition, namely: That there is no more powerful etiological factor in the production of nasal and pharyngeal congestion and hypertrophy and, hence, nasal obstruction than the continual overuse of alcohol and tobacco. The over-zealous specialist, in days gone by, destroyed soft and bony tissues in the nasal passages before he had insisted that his patient should diminish the daily quantity of stimulants and tobacco. But any one who has struggled to cure by local applications the actively congested pharynx of an habitual smoker and drinker appreciates how powerless his efforts have been until a reform in living has been inaugurated. If a serious attempt is made to control such congestion of the nose and throat by surgical measures, a destruction of the entire mucous lining and a consequent traumatic, dry or atrophic condition will be the result. The physician should decline to promise benefit to this class of patients unless they show willingness to cease to abuse their mucous membranes.

An important modification in the surgical treatment of nasal disease was slowly inaugurated when at length it became apparent that the wholesale destruction of the anterior turbinated tissues occasioned what may well be called "traumatic dry rhinitis." A general dryness of the mucous membrane of the upper respiratory tract naturally followed the impairment of the physiological function of the nasal tissues produced by careless operation. I am sure that all specialists have seen most annoying dry conditions of the pharynx and larynx occasioned by ill-advised destruction of nasal tissue. I have in mind as instances of this two singers who are always obliged to contend with this unfortunate dryness of their vocal organs caused by too great destruction of nasal mucous membrane. It was ascertained, too, that the real location of trouble which caused such catarrhal symptoms as hypersecretion and nasal obstruction was not so often situated in the turbinated side of the nose as in the bony or cartilaginous septum. During recent years, intelligent surgical work has been directed to the correction of septal deviations, hypertrophies and spurs.

There was a time, also, when obstructive swellings, situated at the posterior ends of the inferior and middle turbinated bodies, received far more attention than at present. It required considerable skill to transfix a posterior hypertrophy with a long needle, which was considered the necessary procedure to keep the loop of the snare in position over the swelling. This operative measure, even in the most skilful hands, was effected at the cost of a great amount of discomfort to the patient and frequently of considerable hemorrhage. Bleeding in this location was not easy to control, and the necessity of plugging the nostrils added to the general discomfort, and converted what the patient had expected to be an easily accomplished nasal operation into a very annoying one. We rarely hear now of the application of the cold snare to this locality. I think it is the opinion of most rhinologists that swellings at the posterior ends of the turbinated bodies, whether they are composed of dilated blood-vessels or of organized connective tissue, are in both instances secondary and dependent upon anterior nasal obstructions, and are disposed to rapidly disappear when the septal abnormalities have been removed. I have witnessed many times the total disappearance of what seemed to be well organized posterior hypertrophies, whitish-grey in color, and fibrous to the touch, within a week after the anterior nasal openings had been made sufficiently patent, and a proper amount of nasal respiratory pressure had been applied to these posterior growths. When, however, they are persistent, they can be reached by means of cocaine, a self-retaining palate hook, and the application of some one of the chemical caustics, and reduction can be accomplished without bleeding and with little discomfort.

It is easy to recall the days before such a disease as suppurative ethmoiditis was known, and when such a characteristic symptom as a unilateral discharge of pus was hardly sufficient to impress on the mind of the observer the fact that such a nasal discharge could not be evidence of a simple nasal catarrh. Redness and swelling were present and these were deemed sufficient to establish the existence of a catarrhal process. Again, unwisely, agents were employed to destroy tissues which were congested because of the deep-seated ethmoidal trouble and because of the pus, which, coming from the ethmoidal cells, irritated everything with which it came in contact. We may say, also, that frequently the same surgical mistake was made in the treatment of suppurative inflammation of the other sinuses. To-day the diagnosis of sinus disease is accurately made, and the surgical measures for treatment intelligently applied.

Only a word in regard to that large class of disorders which are placed under the heading of either atrophic or dry rhinitis. There it but little opportunity for the destruction of nasal tissue here, no matter how anxious the physician may be to operate, but in the old days some excuse

for either burning an atrophic surface with the electric cautery or removing a portion or the whole of the middle turbinated bone with the cold snare seemed frequently to have been at hand. To-day conservative surgery only permits the removal of as much of the middle turbinated as is necessary to prevent its contact with the septum and to secure proper nasal drainage.

We cannot close this paper without referring to the very greatly improved methods of removing post-nasal adenoids. This condition does not exist at present more frequently than formerly, but its presence is now readily discovered. Children formerly having these enlargements in the nasopharynx which completely blocked the posterior nasal orifices were supposed to be affected with nasal catarrh. Instead of destroying nasal tissue, the post-nasal space is now cleared of all obstruction.

It would require too much of your time, even if it were desirable, to briefly describe the surgical methods which are now applied to the many interesting pathologic nasal conditions. We can only say that the results of surgical treatment in the field of rhinology are vast more satisfactory than they were ten years ago. Earnest workers in the pathology of this department of medical science have simplified the clinical phenomena of many nasal disorders which but a short time ago were not understood, and this increased knowledge, together with a clearer understanding of the etiology of nasal affections, has furnished to the operator great incentive for a most desirable conservatism.

#### STATISTICS OF ONE HUNDRED CASES OF CANCER OF THE BREAST AND THE RESULTS OF OPERATION.<sup>1</sup>

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THE frequency of this disease warrants most careful attention and study, and the early recognition and diagnosis of the condition present are all the more important in the light of the fact that eighty per cent. (according to Billroth, eighty-five per cent.) of all neoplasms of the breast are carcinomatous, and that a cure can be hoped for only when the operation is performed in its incipency. In the following table an attempt has been made to collect the principal points in the histories of the cases of cancer of the breast occurring in the Presbyterian Hospital, New York, from January, 1889, to April, 1899. One hundred cases have thus been tabulated, and the following points elicited:

**Etiology.**—Marriage, child-bearing, nursing or not, and disorders of menstruation have not been proved to have exerted a causative influence. The disease occurs in all social conditions, and persons in perfect health are attacked as often, if not oftener, than those in poor health. In our statistics only two cases had any hereditary taint.

None of our cases developed in pregnancy or lactation, and it is an old saying that a tumor which makes its appearance during either of these periods is almost certainly not cancer. An antecedent suppurative mastitis was present in only three cases.

**Trauma.**—The significance of an antecedent trauma is still under considerable dispute. The situation of the breasts renders them exposed to various forms of injuries, and almost every woman when asked is able to think of numerous times when she has received injuries of greater or less degree to one or both breasts. In our list there is a record on this point in 65 of the patients, of which number 29, or 44.6 per cent., gave the history of a distinct antecedent trauma.

Marriage has been said by some to have a direct influence upon primary cancer of the breast, as high as eighty per cent. being given as occurring among married women. Seventy-four of the patients were married, or 74 per cent.

**Childbirth.**—Forty-eight patients present facts bearing upon this point. Of this number 32, or 66.6 per cent., had borne children, the average number of children to each patient being five. Accurate details as to nursing can unfortunately not be given, as the histories are very deficient on this point.

**Symptoms.**—Unfortunately, for the good of womankind, there are no subjective symptoms in the incipency of cancer of the breast, and the first symptom, in the vast majority of the cases, is the accidental discovery of a hard, not sensitive, painless tumor in the breast, and the absence of pain disarms the patient's suspicions as to its malignancy; consequently, the family physician is not consulted. Pain, as a rule, is not at all pronounced till the surface of the tumor has ulcerated, or till enlargement of the axillary glands has occurred, which press upon the branches of the brachial plexus and cause neuralgic pains down the arm. There may be, however, while the tumor is yet small, a sense of discomfort in the breast, amounting at times, particularly during the menses, to a dull ache. Out of 96 cases, 54, or 56.2 per cent., had some local discomfort or ache prior to operation. It is a remarkable fact that cancers of the breast may attain a large size without the slightest twinge of pain. This may be accounted for by the fact that the advancing, invading cancerous tissue paralyzes the nerve-filaments with which it comes in contact. In respect to pain cancer is somewhat distinguished from benign tumors of the breast, the most frequent of which results from chronic mastitis, which is prone to be a painful process.

Retracted nipple depends on the position of the growth, which will not affect the nipple if it be situated on the periphery of the gland. Retraction of the nipple is caused by the pulling in toward the growth of all the tissues in its neighborhood. Of 73 of the cases about which there is information in this regard, 33, or 45.2 per cent., had retraction of the nipple.

**Situation.**—In 51 of the cases the right breast

<sup>1</sup>Prepared for the Medical and Surgical Report of the Presbyterian Hospital, Vol. IV.



was involved, and in 49 the left. Right breast, the inner quadrant was involved in 21 cases; outer quadrant in 9 cases; left breast, inner quadrant in 10 cases; outer quadrant in 19 cases. In the remainder of the cases the tumor was near the center of the gland. In no case were both breasts primarily involved at once.

**Axillary Lymphatic Gland Enlargement.**—Out of 98 cases, 48, or 48.9 per cent., had the lymphatic glands in the axilla palpably enlarged. It is imperative in all cases of mammary cancer to remove all the lymph-glands in the axilla, even although they may not be palpably enlarged when the axilla is opened; for even in this case microscopic examination often reveals a cancerous invasion of the glands. This is clearly shown in our table, in which the axillary glands of 75 cases, after their removal, were examined microscopically. Out of this number the axillary glands in fifty-nine of the cases, or 78.6 per cent., showed distinct cancerous infection. In Case 13 the axillary glands were both cancerous and tuberculous. There seems to be no rule as to how long a time elapses after the tumor has appeared in the breast before the glands become involved. In some cases it is apparently a simultaneous process, while in others a considerable time passes before changes in the axillary glands are appreciated. Hence, the absolute necessity for as early an operation as possible after the appearance of the tumor. Naturally, the question of prognosis depends largely on whether the axillary glands are invaded or not. Should we not go still farther in our operation and remove the supraclavicular glands? Halsted of Baltimore urgently insists upon this. He excises both the axillary and supraclavicular glands in all his cases, and says the additional time occupied in removing these glands adds nothing to the mortality of the operation. He has cleaned out the supraclavicular fossa in 67 cases and cancer was found in the tissues removed 23 times, or in 34.3 per cent.

**Cachexia.**—This was not a very prominent symptom in our cases and is not apt to develop early. Fourteen cases only showed any cachexia, and these to only so slight a degree as not to contraindicate operation.

**Age.**—The average age was forty-nine years, six months, and twenty-six days, distributed as follows:

Between 25 and 30 years....	1 case.
" 30 " 35 " ....	9 cases.
" 35 " 40 years....	9 "
" 40 " 45 " ....	18 "
" 45 " 50 " ....	12 "
" 50 " 55 " ....	10 "
" 55 " 60 " ....	16 "
" 60 " 65 " ....	15 "
" 65 " 70 " ....	5 "
" 70 " 75 " ....	3 "

The youngest patient was Case 38, who was twenty-nine years of age; and the oldest was Case 1, who was seventy-two years of age.

**Operation.**—The incisions were made so as not

only to remove the infected skin overlying the tumor, but to get so far into healthy skin as to endeavor to avoid any possibility of cancerous infection. The necessity for this is evident when we consider that recurrence most often takes place in the skin around the scar or in the scar itself, and in observing these cases I am led to believe that not enough skin has been habitually removed. The desire to approximate the skin edges should not be allowed to interfere with the liberal excision of skin, as this is of very minor importance when compared to the necessity for a total extirpation of the growth. The dissection is then begun in the axilla and the incision carried down to the pectoralis major tendon, under which, when exposed, the finger is passed and the tendon divided near its insertion upon the finger. The axilla is then laid open by dividing the fascia beneath the great pectoral, and the axillary vein is clearly identified, the situation of which should never be lost sight of as it is the guide to the whole space. The pectoralis minor muscle is now exposed and its tendon divided and reflected back toward the chest with the entire mass. The removal of the pectoralis minor gives much easier access to the very apex of the axilla, and hence greater certainty of removing infected glands, and as the removal of this muscle makes practically no difference in the function of the arm afterward, it should always be removed. The axillary contents, consisting of fat and glands, are dissected back from the apex of the axilla toward the breast. This is a better method of procedure than to proceed from breast to axilla in the dissection, in which case we are more likely to press into the general lymphatic system cancerous cells. The breast, muscles, and axillary contents should all be removed in one piece, since cancerous tissues should never be cut into, nor across, nor removed piecemeal for fear of spreading infection. The subscapular nerves are preserved, if possible, although, if embedded in a mass of enlarged glands, they are removed. The whole mass is then cut away from the chest. This operation seems to be a mutilating one, but the after-results are surprising. One would expect considerable disability after the removal of so much muscle, but such is not the case. The patients may complain for a few months of stiffness and weakness in the arm, but the arm regains its former strength. The functions are maintained by the anterior fibers of the deltoid and the clavicular portion of the pectoralis major. Should the axillary vein be found embedded in a mass of enlarged glands, a portion of it is divided between ligatures. In this case more or less permanent edema of the arm may be expected. A drainage-tube is generally left in the bottom of the wound for thirty-six or forty-eight hours, as there is usually some oozing. The edges of the wound are brought together as closely as possible by sutures throughout the extent of the wound. This is often facilitated by separating the inner skin edge from the chest for two inches back, which

allows this edge to be drawn farther externally. Any defect between the skin edges is allowed to granulate, or if considerable is grafted at the time of the original operation or afterward. Halsted removes so much skin that he is never practically able to approximate the skin edges; to remedy which he always grafts skin at the time of the original operation. After copious dressing has been applied, the arm is bound to the side by a roller bandage, the forearm and hand being allowed to remain free, which adds much to the comfort of the patient.

**Mortality.**—It is one of the remarkable facts in surgery that an operation of such apparent magnitude, which is attended by some loss of blood, and which is at times a prolonged one, should be accompanied by such a low death-rate; the few nerves which are cut possibly account for the small amount of shock. In the following 100 cases, 4 deaths, or 4 per cent., only can be directly traced to the effects of the operation. One patient, Case 85, died three days after operation of suppression of urine; two others, Cases 6 and 22, developed post-operative pneumonia, while Case 18 died four hours after operation from shock. Of the 4 other cases which died in the hospital, the fatal result can in no sense be attributed to the operation. Case 61 died at the end of three weeks from presumably secondary cancerous deposits in the mediastinum and lungs, but this occurred a week or more after the patient had been out of bed. Case 60 died on the thirty-first day of nephritis and some secondary cerebral lesion. Case 63, one of the oldest of the series, died at the end of two months of senile changes. Case 30 died of secondary cancer of brain. This gives an operative mortality of 4 per cent.

Death from sepsis has not occurred. The low mortality-rate leads us to undertake the operation even in cases where we cannot hope to thoroughly eradicate the disease, for the operation will ameliorate the patient's condition and will prolong life. No death is more trying for the patient, and the patient's friends than that caused by an ulcerated, sloughing cancer of the breast, and metastasis of an internal organ is infinitely to be preferred as a cause of death. Mortality statistics of others are: Bull, 3.6 per cent.; Curtis, 6 per cent.; Weir and Dennis, no deaths in a reported series of 125 and 33 cases respectively.

The average length of stay of each patient in the hospital was twenty days. The patients are encouraged to sit up in bed as soon as possible after the operation, generally about the fourth day, and to get out of bed about the seventh day, sometimes even as early as the fifth day. Convalescence is consequently very rapid. Movement is allowed at elbow on the second day after operation and from the shoulder after the tenth day; massage at the end of a week is given to the muscles of arm and shoulder.

**Recurrence.**—We now come to the most interesting part of our report, and we shall en-

deavor to ascertain how much good has been done these patients, and what can be said as to prognosis after operation. To accomplish this an endeavor has been made to get news of each patient in the list; to see personally the ones who are alive, and to get accurate information, when possible, from the physician in attendance, regarding the cause of death in the fatal cases. Of the 92 patients who went out of the hospital, statistics have thus been obtained of 66. No trace has been found of 26, the reason for which can easily be appreciated when we consider the difficulties in the way of tracing patients belonging to the class which we find in the average hospital ward. These statistics were all obtained on or about December 1, 1899.

*Number of Cases free from Recurrence at Yearly Periods from Operation:*

		Per cent.
At end of 1 year	36 cases out of 61, or	59.1
" " 2 years	19 " " "	52, " 36.6
" " 3 " "	17 " " "	50, " 34.0
" " 4 " "	13 " " "	46, " 28.2
" " 5 " "	9 " " "	43, " 20.9
" " 9 " "	3 " " "	37, " 8.1
" " 10 " "	1 " " "	35, " 2.8

If we adopt three years of immunity from recurrence as the limit of time when we can say a patient is cured, 17, or 34 per cent., of the patients were cured.

Halsted of Baltimore published, in 1898, his statistics on cancer of the breast, giving 41 per cent. of cures after three years. Other results of cures after three years are as follows, all published in 1894:

	Per cent.
Bergmann .....	30.2
Billroth .....	4.7
Gusselbauer .....	16.7
König .....	22.5
Volkman .....	14.0
Bull .....	26.6
Curtis .....	20.7
Weir .....	20.0
Dennis .....	25.0

*Table of Recurrence.*

Recurrence has taken place within 3 months in 4 cases.

Between 3 and 6 months	in 7 cases.
" 6 " 9 " "	" 3 "
" 9 " 12 " "	" 7 "
" 12 " 18 " "	" 6 "
At 1 year	" 10 " " 1 case.
" 2 years	" 6 " " 1 "
" 4 " "	" 2 " " 1 "

Four patients died of recurrent cancer, in whom the time of recurrence was not ascertainable:

One at 2 years.....	Case 73
" 2 months.....	Case 68
" 3 " .....	Case 26
" 6 " .....	Case 42



It is, therefore, clear from these tables that all the recurrences took place within two years of the operation, except in two patients, one of whom (Case 67) died four years and three months after operation of cancer of the lung. Shall we call this a recurrence after four years, or is it not truly a case of re-infection, in which the original disease had no influence? The second patient (Case 53) died two years and six months after operation from cancer of the brain. Twenty-one cases recurred in the first year, and twenty-eight within two years. There are some interesting statistics concerning the location of the recurrences:

#### Recurrence.

Local, in scar or skin about scar,	in 15 cases.
" " lung	" 6 "
" " opposite breast	" 3 "
" " liver	" 2 "
" " brain	" 2 "
" " supraclavicular glands	" 2 "
" " stomach	" 1 case.
" " pleura	" 1 "
" " locality unknown	" 2 cases.

The clinical history subsequent to operation of several of the cases is interesting.

Case 17 had a small tumor of breast, of five months' duration, removed July 1, 1897, by Dr. McCosh, which, after careful pathological examination, was found to be chronic inflammation. Eleven months afterward another tumor appeared in the same breast, and this time a radical operation was performed, the breast, pectoralis major, and axillary contents being removed. Pathological examination of the breast tumor revealed "Chronic inflammation, with much proliferation of cells," while the axillary glands showed carcinomatous infection. Twelve months later, metastasis took place in liver. The patient is still alive, but very ill. How are we to explain this case? How much influence had the chronic mammary inflammation to do with the axillary cancer?

Case 37 had one breast removed by a radical operation for cancer, June 23, 1897. Without any local recurrence, a tumor appeared in the opposite breast April 1, 1898. Radical operation was performed in April, 1898, and the tumor and axillary glands pronounced to be cancerous. No recurrence was discoverable December 1, 1899, two years and five months after the first operation, and one year and eight months after the second. The patient has perfect use of both arms and works for her living.

Case 53 was exceedingly interesting. For notes on this case I am indebted to Dr. Stillwell. The breast was removed radically June 23, 1896. The patient was well for two years and six months, when, in December, 1898, she began to complain of difficulty in expressing herself, and of dulness of mind. Three months later, March 9, 1899, she developed some loss of muscular power in the right arm, difficulty in concentrating the mind, and slowness of speech. Was also

emotional. Had no headaches. March 17th, right arm showed marked loss of muscular power. Pulse absolutely normal; also kidneys and lungs. Sensation normal in right arm. Cerebration was sluggish; did not confuse words. No headache, no vomiting. March 28th had a severe chill, and during day had three fainting attacks, in which pupils were contracted but equal, was semi-conscious, and total paralysis of right arm and leg developed. March 29th, after use of powerful cathartics, intelligence cleared up, paralysis became much better, *i. e.*, had slight movements in arm and leg (alleviation of symptoms possibly being due to the relief of cerebral edema), March 30th, greatly improved, pupils normal, could read intelligently, and talked well. April 2d, pulse was '68, no fever. Mind sluggish and drowsy. Speaks correctly when questioned, but in monosyllables. April 3d, slight dysphagia developed, moves leg fairly well, but arm not at all. Seems weaker, no vomiting, no headache. April 4th, mentally clear. Can move arm slightly. April 5th, moves arm slightly, clear mentally up to end, no vomiting nor headache at any time. Pulse, 120, action weak and heart bad; breathing became labored, and she died suddenly April 5th. Autopsy showed that the two vertebral arteries were not obliterated, only slight general atheroma. Left anterior and middle lobe centrally softened, so that section was impossible; and under the convolutions and in center of this soft mass, was a hard, sharply defined mass, the size of a small egg. Microscopical examination showed this to be medullary cancer.

Case 38 died eighteen months after operation of metastatic cancer of the brain. She was well for nine months, when she began to complain of headaches which were intractable. Four months later the headaches became agonizing, particularly at night, and rendered sleep impossible. Left-sided facial paralysis developed two months before death, and paralysis of speech two weeks before death.

Death has taken place in the recurrent cases on an average one year, two months and twenty days after the operation. The average length of time after recurrence set in till death took place has been five months.

In concluding the subject of recurrence and considering the facts before us, we are, unfortunately, obliged to confess that we can never promise to absolutely cure a patient with cancer of the breast by operation. If the case is seen while the tumor is yet small and there is no axillary gland involvement, we can tell the patient's friends that a cure is very possible, but not by any means certain. We know we can cure a certain number; but our knowledge is not as yet deep enough to select from a given number of cases those which will not have a recurrence, and those which will recur. Thirty-four per cent. of these cases, we have seen, were cured (*i. e.*, passed the three-year limit without recurrence). This percentage is not absolute, however, because not all the patients operated on over three

years ago could be found, consequently we know not whether this percentage would be increased or diminished had we been able to trace them all. The fact remains, however, that at the end of three years, 17 patients were perfectly well, which is a very excellent showing compared with earlier results, and well calculated to convince any who may think the operation of doubtful utility. With recurrence taking place in the scar or its neighborhood in 15 of the cases, it would seem that it has not been the custom to remove enough skin with the breast. Have we sufficient warrant to subject the patients to the additional ordeal of removing the supraclavicular glands, in view of the fact that in only two cases was recurrence primarily in these glands? If the process has gone on so far as to infect these glands, is not a general infection very probable, and will their extirpation be more likely to effect a cure?

These considerations are worthy of careful attention. The tendency is to extend the operation. Where shall the line be drawn?

In conclusion, I venture to assert that many of the profession feel that this is an operation which is merely palliative. These statistics prove that such a feeling is a false one, and calculated to do immense harm. It is the duty of the profession to impress upon the laity the idea that the smallest nodule in the breast may become a source of the greatest danger to life, and that the only hope of a cure lies in early and radical operation. A summary of the points elicited in the preceding article, as well as a table of the cases follows:

#### Summary.

- Trauma present in 44.6 per cent. of the cases.
- Married, 74 per cent. of the cases.
- Children born to 66.6 per cent. of the cases.
- Average number of children to each, 5.
- Pain present in 56.2 per cent. of the cases.
- Nipple retracted in 45.2 per cent. of the cases.
- Right breast involved in 51 cases.
- Left breast involved in 49 cases.
- Axillary glands palpable in 48.9 per cent. of the cases.
- Axillary glands found cancerous by microscope, 78.6 per cent. of the cases.
- Average age was 49 years, 6 months, 26 days.
- Mortality of operation was 4 per cent.
- Average length of time in hospital, 20 days.
- Prolongation of life for one year, 59 per cent.
- Prolongation of life for two years, 36 per cent.
- Cured (no recurrence at end of three years), 34 per cent.
- Recurrence took place in one year in 21 cases.
- Recurrence took place in two years in 28 cases.
- Recurrence took place locally in 15 cases.
- Recurrence took place in lung in 6 cases.
- Average length of time in recurrent cases from operation to death, 1 year, 2 months, 20 days.
- Average length of time from period of recurrence to death, 5 months.

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#### CANCER OCCURRING IN ACID PARTS OF THE BODY.

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THE relative frequency of primary cancer occurring in the stomach as compared with cancer of the bowel, and of cancer of certain small portions of the bowel as compared with the greatest part of the small intestine, must often have appealed to the student of digestive diseases as possessing a hidden significance. The recent suggestion—it can as yet scarcely be given a more positive term—that cancer is due to a micro-organism analogous to, if not identical with, the yeasts, has led the writer to undertake an investigation of statistics to learn if the reaction of different parts of the body has any determining influence on the location of cancer. All the juices of the body are ordinarily alkaline in reaction, excepting four, *vis.*, the perspiration, urine, gastric juice and cervicovaginal mucus. It may be said in anticipation that whether the essential cause of cancer be a yeast, some other kind of germ, or merely an excited epithelial vitality, statistics show that the great majority of cancers develop in acid media. Whether the reaction is the determining factor, whether, as is certainly often the case, acid parts of the body happen to be parts in which mechanical traumas are frequent, or whether the localization is due to some unsuggested cause, the writer does not pretend to state. In fact, he prefers not to be considered an advocate of any theory, so long as the etiology of cancer remains obscure. It is, of course, understood that this paper deals with primary cancers, and that nothing is suggested to confirm or reject the commonly accepted ideas as to metastasis.

Especially with reference to the digestive tract, it is important to bear in mind certain facts. While all the secretions of the alimentary canal and its tributary glands (the salivary glands, liver and pancreas) are alkaline in reaction, except that of the intramural gastric glands, organic fermentation plays a very important part in determining acid reaction in certain places. Food particles in the mouth, especially along the dental margins and in the tonsillar crypts, are prone to ferment, producing various organic acids to which was, indeed, ascribed the production of dental caries until the development of bacteriology as a fairly exact science within the last fifteen or twenty years. The corners of the mouth, the gums, the portions of the tongue not readily cleansed by its own movements and especially the parts near the circumvallate papillae, the tonsils, are preëminently the parts selected by cancer. The esophagus is subject to little interference from without, except at meal-times, and is bathed in a tenacious, alkaline mucus for more than nine-tenths of the time, except at its inferior extremity, where it is exposed to acid regurgitation from the stomach for quite a time



after each meal. It is at this point that most esophageal cancers are located. (Pepper's System, or, in fact, any authority.) The duodenum is, for several hours after each meal, subject to periodic waves of acid chyme. The small intestine below the entry of the pancreatic and hepatic secretions is uniformly alkaline, except for fermentation in the central mass of chyle. There is free secretion, exceeding the amount lost by absorption under ordinary conditions; the absorption is by means of projecting villi and all absorbable products are fresh from the activity of alkaline secretions. Thus, the mucous membrane is protected by an abundant current of alkaline secretion from whatever irritating acid masses may be present in the lumen of the bowel. In the large intestine, or even a little before the ileocecal valve is reached, the conditions change. Bacterial fermentation becomes more marked, the amount of secretion from the intestinal wall is absolutely less than in the small intestine and the current is one of absorption toward the mucous membrane, which must, therefore, often be subjected to an acid irritation.

Cancer statistics are by no means satisfactory. For instance, the first question that naturally presents itself is as to the classification and enumeration of cancers according to the blastodermic layer from which they are produced. It is, of course, obvious that, except for an inclusion of stray cells in development and that the cells of organs derived directly from the so-called genitourinary cell-mass always retain a vestige of power to develop into any kind of tissue, cancer can occur primarily only in epiblastic and hypoblastic epithelium. Yet there are no statistics of any magnitude bearing on this question, and it is not even easy to obtain positive general statements regarding the blastodermic origin of different cancers, or an explanation of the characteristics of cancers of different organs, with their cellular genealogy in view.

Tyson states that barely five per cent. of all intestinal cancers occur in the small intestine, yet this part of the bowel has eighty per cent. of the total length and probably 70 per cent. of the total epithelium. Fifteen per cent. occur in the cecum and colon. All detailed reports of small series agree that the great majority of this group are located within a few inches of the ileocecal valve. Eighty per cent. occur in the rectum, which comprises not more than three per cent. of the entire bowel. This part of the intestinal tract is not subjected to the constant presence of contents and bears the brunt of the chemical irritation only at times.

Maydl collected at the Vienna Pathologic Institute 41,838 necropsy reports, including 3,583 of cancer. Only 343 of these affected the intestine, although the majority of the total hypoblastic epithelium is found in its wall. Of the 343 intestinal cancers, 162 occurred in the rectum, 164 in the colon, which is more than four times as long, and 7 in the duodenum. Not one is charged to the jejunum and only 10 to the ileum.

Although their exact location is not given, it is safe to assume that most of them, as in similar series, were well down toward the ileocecal valve. In fact, Alois Pick, alluding to these very statistics, although not in detail, makes this statement. Thus, of the 343 intestinal cancers, only a minority of the last ten occurred in distinctively alkaline parts of the bowel, although the latter comprise a length of about twenty feet, as contrasted with about two feet of the points of election for the majority of cancers.

Primary cancer of the spleen (inclusion growths), pancreas, gall-bladder and liver, is comparatively rare, although all except the spleen represent considerable aggregations of hypoblastic epithelium. Fully three-fourths of all cases of hepatic cancer, according to Tyson, are secondary to growths in the stomach, and Welch is in practical agreement, putting the fraction at two-thirds. Musser, from a study of 100 cases of cancer of the biliary ducts and bladder, says that primary growths are rare and usually due to previous irritation by gall-stones. These, in addition to their mechanical irritation, are now known to be connected with bacterial invasion, especially of the colon bacillus, which produces hydrosulphuric acid from nitrogenous pabulum.

If we consult any large series of cancer cases, barring some with peculiar standards of selection, we find that the plurality of cancers is possessed either by the stomach or the uterus, both acid organs and of relatively small size. Welch's average of 31,482 cases from various European and American sources was 21.4 per cent. for the stomach, 29.5 per cent. for the uterus. The latter really represents about double the apparent tendency, being limited to females. It is only fair, however, to consider the fact that cancer is rare in nulliparæ and that traumatism must have an important bearing. Still, it is a question whether the traumatism is a direct cause or whether laceration of the cervix acts by exposing the cervical epithelium to chemical irritation from the vagina.

In considering any series of statistics regarding epithelioma alone, the acid theory receives confirmation which is largely specious, since squamous epithelium occurs to a slight extent inside of the skin. This is bathed in acid perspiration and to a greater or less degree, in fermenting sebaceous matter. Satterthwaite's series of 94 cases of epithelioma ("Reference Hand-Book of the Medical Sciences") assigns twenty-five per cent. to the lip, six per cent. to the tongue, three per cent. to the larynx, two per cent. each to the mouth and palate. Löwenthal published in 1895 a series of 800 cases of apparently traumatic tumors, including 358 cancers of which 152 occurred in the breast, where special reasons for such growths occur. I may digress to state the belief that the history of gross traumatism of the breast has been given undue prominence. Aside from physiologic stimuli, occurring not merely with lactation but with every menstruation, the breast is frequently the seat of mild traumatism,

not only from nursing but in caresses and by the pressure of the corset, etc. Just half of the remaining 206 cancers occurred in the face, but the avowed purpose of the collection, the tabulation of traumatic growths, would inevitably include a disproportionate number of face cancers. In this connection, it may be remarked that few cancers appear to be due to shaving. Men show no marked predisposition to facial epithelioma. It occurs about as often in those men who wear beards as in those who shave, and it usually occurs above the line of the beard. But it would be too far-fetched to explain this on the ground of a liberal application of alkaline lather to the area of shaving. Löwenthal's other figures are as follows: Jaw, 16 per cent.; neck, 1 per cent.; back, 2 per cent.; abdomen, 8 per cent.; upper extremities, 18 per cent.; lower extremities, 26 per cent.; urinary organs, 17 per cent.; pelvis and lumbar region, 0 per cent. Thus, the limbs are more liable to cancer than the trunk. In proportion to their size, there is no significant difference between the arms and legs. The urinary organs certainly show a proportionately great liability, perhaps due to the fermentation of urine, smegma, etc., and to relatively free perspiration. The axillæ and umbilicus, although subject to free perspiration and fermentation of sebaceous matter, are quite free from cancer.

Of 180 scirrhus cancers collected by Satterthwaite, 130 involved the breast, including the nipple. The fact that cancers, as well as pyogenic affections of the breast, often begin at the nipple may be taken to show a predisposition on account of acid fermentation, which is certainly frequent at this point. But we must not overlook the fact that the mammary glands, although epiblastic, resemble, both histologically and in the character of their neoplasms, hypoblastic structures, and that no other epiblastic tissues are fairly comparable with them. Of 50 other cases of scirrhus, 35 occurred in acid parts; stomach 18 (with metastasis to the liver in 4), uterus 8, rectum 4, bladder 2, colon, duodenum and ileocecal valve, 1 each; while distinctly alkaline parts were affected in only three cases; pancreas 2, gall-bladder 1; and twelve cases occurred in parts of doubtful reaction; or the location of the tumor is not given exactly enough to warrant a definite conclusion; neck 4, axillary glands, back, foot, nose and parotid region, superior maxilla, cheek, esophagus, each 1. If we assume that the cancer of all of the skin-covered regions of this list of 12, began in the skin epithelium, 10 more can be claimed as occurring in acid parts.

Satterthwaite's series include only 10 cases of medullary carcinoma and this series neither supports nor opposes the acid theory, unless we assume that important glands like the liver and spleen are in a state of acidity during functioning periods—for which there is good physiologic authority as regards the spleen, at least. If, in addition, we assume that the mammary cancers originated at the nipple, every one of this series of 10 may be assigned to acid parts. Only 2,

however, occurred in parts having a practically permanent acidity, the kidney and vagina.

The United States census of 1890 reports 18,536 deaths from cancer, a little more than two per cent. of the total death-rate. Of these, 5793 are unspecified in location or are referred in a general way to the abdomen. Of the 12,743 specified cancers the location was as follows: Stomach, 4307; uterus, 3510; bladder, 124; genitals, 57; rectum, 414; head, face and neck, 1206; extremities, 169; making a total of 8787 occurring in distinctly acid parts. Breast, 1714; liver, 1293; mouth, tongue and throat, 642; a total of 3649 which occurred in parts of doubtful reaction. Brain, 51; eye, 72; larynx, 46; lungs, 79; ovaries, 49; testes, 10; a total of 307 which occurred in alkaline parts.

Cancers of the pancreas and small intestine were lumped together in an item of only 923 abdominal cancers, obviously including the kidneys and extensive growths from the stomach as well as the lower bowel. It is also incredible that 10 per cent. of all cancers originated in the liver. Fully 6 per cent. of these should be charged to the stomach, according to Welch's opinion. But without any of these allowances, it is significant that about 70 per cent. of all cancers occurred in distinctly acid parts, only about 3 per cent. occurring in distinctly alkaline parts.

William's statistics, based on reports of English hospitals and limited to primary neoplasms, are as follows:

For males, total 4597, 15.9 per cent. being unspecified or undetermined. In acid parts there were: Tongue and mouth, 15.9; skin, 16.4; external genitals, 6.1; rectum, 5; stomach, 4.8, and prostate, .2, making a total of 48.4. Those of doubtful origin were: Lips, 7.3; maxillæ, 3.9; mammae, .5, and esophagus, 3.1, making a total of 14.8. Those occurring in alkaline localities were: Connective tissue, 9.4; other bones, 6.1; brain, 3.4, and testes, 2, making a total of 20.9.

For females, total 9227, 5.8 per cent. being unspecified or undetermined. In acid parts there were: Uterus, 28.7; skin, 5.9; external genitals, 4.6; rectum, 2.5; tongue and mouth, 1.6, and stomach, 1.4, making a total of 44.7. Those of doubtful origin were: Mammae, 26, and maxillæ, 2.4, making a total of 28.4. While those occurring in alkaline localities were: Ovaries, 8.7; connective tissue, 6.9; bones (except maxillæ), 2.9; brain, 1.4, and liver, 1.2, making a total of 21.1.

The discrepancy between these and the preceding statistics is easily accounted for by the nature of the series. Williams deals with surgical cases and his statistics were published before operations for radical cure of neoplasms of the stomach, liver, etc., were at all frequent. Thus, instead of tabulating 25 or 30 per cent. of gastric cancers and 2 or 3 per cent. of (primary) liver cancers, he notes a low percentage of each. The fact that he was a general surgeon rather than a gynecologist is shown by the fact that he saw only 28.7 per cent. of uterine cancers among wom-



en, whereas such cancers amount to as high a percentage of the total population, *i. e.*, to about double Williams's percentage of cancers for women. In fact, what Williams takes as 100 per cent. really represents only about 70 or 80 per cent. of the total cancerous population, or rather of an average representation of it.

It is proper to call attention to the relations of this theory to other more or less accepted views as to etiology. To the microbic theory of cancer, whatever be the exact nature of the germ, the acid theory applies merely with regard to the localization of the growth, and it is certainly in harmony with our knowledge of other infections, notably tuberculosis and diphtheria, to suppose that special characteristics of a tissue influence the development of the disease. The dry, squamous epithelium of the skin shows comparatively little predilection for cancer, nor does one area seem notably more prone to cancer than another of the same size. While the marked liability of the genitals and other muco-cutaneous areas as compared with other parts of the skin might support an argument for the acid theory, it is only fair to suppose that the softness of the epithelium has more to do with this tendency. If we contrast the bladder and rectum, on the one hand, with the mouth, nose and throat, on the other, we have nearly equal areas of infolded epithelium, the latter much more subject to traumatism, but each group subject to cancer in nearly equal degree. In referring to the stomach as an acid cavity, the idea is based not so much on its normal secretion of HCl as on the liability to organic fermentation. In conclusion, the writer wishes again to emphasize the fact that he is not a partisan of a theory, but that these statistics are presented as a basis for further study.

#### AFTER-TREATMENT OF TENOTOMY.

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AFTER a tenotomy, whether performed for a squint or heterophoria, there are two plans of treatment open to us. We may either bandage the eye operated on and discourage any attempts at using the eyes, at least for binocular vision, until the wound is healed; or we may leave the eye open immediately after the operation and encourage the patient to begin using his eyes at once for all ordinary vision. In the first method we aim to fix the eye in the position left by the operation, except so far as we modify that position by another operation, *e. g.*, by the insertion of sutures, etc.; in the second method we attempt, by utilizing the directive force of the eyes themselves and, if necessary, by suitable exercises, to gradually substitute a more accurate correction for the approximate one produced by the tenotomy.

The principle underlying this second plan of

treatment, to which I in common with others give the preference, is as follows: If there still remains any tendency to binocular vision, the eyes, even although deviated, will constantly strive to assume their proper relations to each other, so far as they can. Under ordinary circumstances, this effort is nullified, indeed sometimes reversed, by the conditions acting to maintain the deviation. But in the days immediately succeeding a tenotomy, when the tissues are still plastic and the severed tendon still able to shift somewhat its point of attachment to sclera, this tendency to spontaneous restitution is able to assert itself and acts gradually, but automatically, to set the eyes straighter than we left them by our operation. It is our part to give this tendency full play. Accordingly, after detaching the tendon from its insertion and putting it as nearly as we can in the place desired, we allow this automatic action of the eyes at once to begin working, so that it may act to the best advantage and gradually put and keep the tendon in just the proper position. In this way we convert an approximate result into a more precise one; just as the microscopist supplements his coarse adjustment that brings the object incompletely into view by a series of fine adjustments which focus it sharply.

Being thus left open and free to move, the eyes are *practised from the moment of operation in looking*, especially in steady looking at remote objects. Care should be taken that at first they are used mainly for distant vision—certainly for no very fine or continuous near work—and that the patient avoids all sudden, jerky movements of the eyes or head as well as any stooping and straining. Measurements of the amount of heterophoria are made every day, and from these measurements deductions are drawn as to the amount and kind of eye-work that the patient may be permitted to do.

Obviously, the eyes should be placed in the very best conditions for seeing, and all accommodative strain eliminated, *i. e.*, the *refraction* should be corrected as accurately as possible. If the error, whether over-correction or under-correction, left by the operation, is small, the eyes may eliminate it by simply practising in the way above indicated without artificial aid. Whether this is going to be so or not, we can judge from our daily measurements of the heterophoria. If not, that is, if we find that the residual deviation remains stationary or tends to increase, or if it is very large, at the outset, we then try to supplement the automatic action of the eyes by *appropriate exercises*.

Thus suppose that after a tenotomy of the left internus we find an esophoria of 3° or 4° left. This is an amount that our experience in such cases shows us will probably increase by several degrees during the process of healing. If we do not feel justified in extending the effect of our operation by further tenotomy, we will immediately begin exercising the eyes, once or more times daily, according to circumstances, by practising the divergence with prisms, base in, and

<sup>1</sup>Read before the Section on Ophthalmology and Otology, New York Academy of Medicine, March 19, 1900.

by making the eyes execute strong lateral movements to the left. Similarly, if after a tenotomy of the right externus there remains an exophoria of the smallest amount, an exophoria that we are morally certain will increase, we practise the convergence by the systematic daily use of prisms, base out, and by making the eyes converge upon very near objects; and we further stretch the divided tendon by making the eyes execute lateral rotation movements to the left.

Similar principles of treatment obtain if after an operation we have, instead of an under-correction, as in the examples cited, an *over-correction*, so great that we think it necessary to reduce it. No specific rules can be laid down for such cases. In each, we judge by the progress made from day to day, and, by the results of our measurements from day to day, how far to push our exercises and when to stop them altogether.

Exercises of this sort made with prisms must not be confounded with similar exercises made upon eyes in which the tendons are intact. These are different in principle and, in my experience, considerably different in result. When we undertake to cure an esophoria by exercise with prisms, base in, we simply stimulate the diverging power of the eyes and by this means hope to offset the continuing causes that produce the undue convergence. In this attempt we usually—I think it scarcely too much to say that we invariably—fail. But when after an operation for esophoria we exercise the eye with prisms, base in, we aim, not so much to practise the divergence *per se*, as to pull upon the severed and yielding tendon and get it to attach itself a little nearer the right position. And in this we not infrequently succeed.

So, too, exercise with prisms, base out, undertaken for the cure of an exophoria, simply means exercise of the converging power, enabling the patient better to fight against the continuing causes producing the deviation, but not removing these causes themselves in their entirety. Such treatment is very often disappointing. But when we exercise the eye with prisms, base out, after an operation for exophoria, we then make the eye pull in against a divided tendon, and aim to stretch the latter so as permanently to affect its place of attachment. This is a procedure much more likely to be successful.

The same procedure and the same class of exercises that are of use in supplementing operations for esophoria and exophoria are equally applicable to *vertical deviations*. Indeed, experience has convinced me that the tendency to spontaneous correction after operations on the vertical muscles is even stronger than in operations on the lateral muscles; and the after-treatment is more important as yielding results that are apt to be both more permanent and more satisfactory.

When the amount of post-operative deviation, especially if it is an under-correction, is very large, little is to be expected either from attempts to get the eyes to perform binocular vision spontaneously or from exercises with prisms. It is

best, then, to *modify the operation* by any one of the well-known surgical procedures in order to get a closer approximation to the true correction, before proceeding with the exercises. When such an extension of the operation would seem to hamper too much the mobility of the operated eye, it is better to operate on the other eye and secure the desired effect from that. If, however, the original operation is carefully performed and is checked by rigid quantitative tests, made at intervals during it and directly afterward, there should not be in most cases such a large residual error as to require much subsequent operative readjustment.

The *duration* of the treatment will vary much in the individual cases. Perhaps two weeks may be stated as the average time of active treatment with exercises. During the first week the patient is seen and examined every day; during the second week, every day or every other day, according to circumstances; after that at longer intervals, unless there is some special indication for seeing him oftener, such as the presence of a large deviation or the recent performance of a secondary operation. In any event, it is advantageous to keep some sort of supervision over the case for a month or more after the operation. After the first few days, much of the exercising may be entrusted to the patient himself, if intelligent; but even then the progress of the case ought still to be constantly watched, and daily tests made to gauge the results of the treatment.

Of course, the likelihood of success is much enhanced if the patient starts with good binocular vision. Hence, as many have realized, one important element in the treatment consists in training the patient before the operation to *recognize diplopia and to see binocularly* if possible. With care and patience this may often be effected even in apparently unpromising cases. The various well-known expedients for differentiating the double images, and thus enabling the patient to recognize them better, may be used, the only proviso being that they are used repeatedly and systematically. Such expedients are the red glass and particularly the Maddox rod placed over either eye; or a strong convex glass placed before the better eye to reduce the distinctness and change the character of the image formed by it. Prisms that only partially correct the deviation are often useful. Such a prism may make double images, recognizable either because it brings them close together when they were previously too far apart to be perceived, or simply because it gives them a relation different from the one to which the patient is accustomed. This is particularly the case if we employ, one after another, prisms of different strengths. This causes a changing diplopia, which, as experience teaches us, is harder for the patient to ignore than is a diplopia that is constant. We all know how inapt an eye is to ignore the double images produced by a paralysis; the reason evidently being that the diplopia is constantly shifting, so that the patient cannot learn to make allowance for it.



as he can for one that is always the same. We produce a similar effect with our changing prisms.

This training, which is useful before operation to enable the eyes to recognize double images and seek their fusion, is also and to even a greater degree useful after operation. This is a matter that has been so abundantly worked out by many and competent investigators that it seems scarcely necessary to refer to it, except to say that exercises of this sort are not employed so much as they should be, and are rarely initiated at the time when they would appear to be most serviceable, namely, in the first hours and days after the operation, when we are able to modify to the greatest extent the operative result. At this time our other exercises work to produce binocular fixation; and our likelihood of success will certainly be considerably better if we then secure some measure of binocular vision as well.

There is one other point relative to the preliminary treatment to which I should like to advert. This is the practical utility—likewise recognized by a number of observers—of exercising the patient *before the operation in the use of the eye-muscles* themselves. We practise him, that is, with and without prisms, in making divergent, convergent, and lateral movements, until he acquires as fair a degree of facility as the ocular conditions will allow. This practice will enable him to pursue his post-operative exercises to much better advantage.

To recapitulate, the principles of treatment here advocated are as follows:

First, the patient is *prepared for the operation* by repeated exercise of the eye-muscles and by repeated attempts to secure binocular vision and the recognition of diplopia. This may take but a few days or it may require a week or more.

Second, the operation, however performed, is *checked* all during its performance and immediately afterward by careful tests calculated to show the precise amount of deviation present at each step of it.

Third, *immediately after the operation* the patient is allowed to go about as usual, is encouraged to use his eyes for distant vision, and is urged to practise both eyes together for all ordinary looking. This practice is kept up daily, and daily tests are also made of the amount of deviation. If this is large and is not diminishing satisfactorily, exercises are instituted to stretch the divided tendon, so as to secure its adhesion in a better situation than where it was left by the operation. These exercises are particularly necessary when the operation has left an under-correction.

No bandage is applied, and deep sutures are avoided when possible. I generally instil a sterile salt solution or preferably a weak solution of sublimate, as the latter, it seems to me distinctly promotes the healing of the wound.

It will be observed that I have not mentioned as part of the post-operative exercises the *occlusion* of the better eye and the systematic practis-

ing of the amblyopic eye in monocular vision. In fact, I do not think that this procedure should find place until the eyes have first been thoroughly trained in binocular vision or, at least, in binocular fixation. Hence I should prefer to reserve the use of this expedient until a period some considerable time after the operation.

What *objections* are there to the method of treatment here outlined? The first that naturally suggests itself, *vis.*, delay in healing and the risk of exciting inflammation of the wound, is not in my experience valid. These wounds of the conjunctiva and ocular tendons, as is well known, are painless and heal without any inflammatory reaction. As is also known, the parts concerned will stand an extraordinary amount of manipulation without reacting in any way. And certainly the moderate straining and pulling produced by the exercises have never, so far as I have seen, caused any untoward effects.

The danger of *infection* may be urged. But, while conjunctival inflammation or even tenonitis has occurred as a very rare accident after these operations, such an event, as I understand the matter, is ascribable to infection at the time of operation due to contaminated instruments, and not to infection taking place subsequently through the atmosphere. In fact, there appears to be no reason to believe that such accidents are any more frequent with the open method than when an occlusive bandage is employed. At any rate their extreme rarity practically excludes them from consideration, and the added security and permanence of results that accrue from the open method surely more than counterbalance any such remote danger.

A more valid objection is that the patient by sudden movements of the eyes or undue use of them may strain the fibers holding the tendon in place, and produce an *excessive effect*. The likelihood of such an occurrence, however, is more apparent than real. It can practically always be avoided if we take pains to tell the patient just what he can and can not do with the eyes, and insist upon his observing ordinary precautions. If an accident of this kind does happen and if we feel that the over-effect is going to be permanent, we can insert a suture and draw up the retracted tendon. Only, it is to be remembered that such an over-effect is often transitory, and it is well, therefore, to wait a day or two at least before attempting to remedy it with a suture—in the meantime, of course, stopping the exercises or even reversing them.

To conclude: The method here outlined has been employed, either in part or in its entirety, for many years by a number of operators. My own acquaintance with it covers a space of about fifteen years. From that experience I feel sure that this procedure gives greater certainty of results and especially greater stability of results than any other. So persuaded am I of this that I have come to regard the technic of the operation as of subordinate importance. In other words, I believe that we can not hope to effect

an absolute correction by the operation *per se*, however delicately performed. What we can do by the operation is to set the eyes fairly straight and in a position in which, being left free to move, they themselves will work toward an absolute correction. Hence, I say that, provided it is done with care and discrimination, and is checked by precise measurements made during and after its performance, it makes little difference how we do a tenotomy—but it makes a great deal of difference how we treat the eyes afterward.

#### INTERESTING CASE OF SYPHILIS: EPITHELIOMA.

By L. BLAKE BALDWIN, M.D.,  
OF CHICAGO.

*Case I.*—Man, thirty-seven years of age, American, of German parentage; salesman; unmarried. When seen, November 4, 1899, he presented the following conditions: On the vertex were four ulcers, each two cm. or more in diameter. Over the right supraorbital ridge was an ulcer about 1.5 cm. in diameter. Each of these was covered with a crust from 5 to 10 mm. in thickness. Over the left parietal region was the partially healed remains of an ulcer represented by a cavity about 5 mm. in depth. The entire nose as far back as the bony septum was gone, the remaining portion being a crust barely one cm. in thickness. The left side of the soft palate was entirely gone and the right side badly ulcerated. Upon the right arm was an ulcer about 1.5 by 2 cm. in dimension. The right forearm from above the elbow-joint to the wrist upon its extensor surface presented an almost continuous ulcer. The left forearm presented the same condition excepting that the elbow-joint was not involved. Both thighs, on their external surfaces, from the upper third to the knee presented numerous ulcers, none of them less than 2 cm. in diameter. Upon the inner surfaces there were several. The tibial surface of both legs from the knee-joint to the ankle was an almost continuous mass of ulceration. The calf of the left leg was covered with an ulcer which extended from the junction of its upper and middle thirds to near the ankle and which extended transversely nearly one-third of the circumference of the limb. The right great toe had upon its extremity an ulcer which had progressed nearly to the bone. The second toe of the same foot was covered with an ulcer extending from the base to the tip. The discharge from these ulcers was exceedingly profuse and fetid, so that although the patient lived upon the third floor rear, and the door of his compartment was kept closed, upon entering the hall from the street the odor was sickening. The family, in fact, had been threatened with eviction by the landlord.

In addition to these areas of active ulceration there were upon his trunk the remains, for the most part healed, of over eighty lesions, none of them less than one cm. in diameter and ranging

in size from that up to half the size of one's hand. These eruptions had all taken place within the previous fourteen weeks. There were in all 284 ulcers. His emaciation was extreme, his weight having fallen from 178 pounds to less than 90 pounds within that time. The face was colorless; articulation was difficult. Liquid food only could be taken, and that with pain. Unassisted the patient could not lift his head from the pillow. The right hand could be raised to the mouth; the left arm not at all. So great was his weakness that practically no power of movement remained in the lower extremities. His stomach resisted five-grain doses of potassium iodide. He gave a history of chancres seven years previously, which had been cauterized, and, after a few weeks' treatment, having been discharged—cured.

He was placed upon the following treatment: Wet bichloride of mercury dressings were applied to all ulcerated surfaces excepting upon the cranium, and ordered to be constantly kept wet, being renewed once in twenty-four hours. After the first week the wet dressing was applied to the head, but a few days being required to remove the crusts and stop suppuration. Internally he was given the pure juice, seasoned with salt and pepper, of five pounds of beef daily, which amount was increased during the first week to that of eight pounds of beef. He was also given forty grains of potassium iodide, three times daily, the dose being increased during the first week to 115 grains t.i.d.

Following the removal of the crusts and cessation of the suppurative process, the ulcers were dressed with Unna's emplastrum hydrargyri mull. On the eighth day he sat up in bed to eat. On the tenth day he walked with crutches, and on the fourteenth day he walked to his meals unassisted. It is now two months since the first consultation, and he weighs 187 pounds.

*Case II.*—Woman, forty-one years of age, married, Polish, in America thirteen years. Eleven and a half years ago a pimple appeared upon the left cheek, which gradually extended, spreading over the nose, both cheeks and surrounding the eyes, producing pronounced cicatricial ectropion and leaving white scar-tissue in place of the normal skin. This process from first to last covered about one year in time and was painful and itched. From the face the lesion spread to the right side of the neck where it remained quite stationary for about seven years. During the past three years the activity of the process has been revived and now completely encircles the neck, extending in front of the right ear on to the cheek for about 5 cm. in front of the inferior maxillary angle, and down the sternum as far as the ensiform.

Within the past year a separate lesion has appeared upon the right breast which now measures about 6 by 15 cm. Within the past three months a new lesion has appeared upon the face, commencing as a pimple on the right cheek near



the base of the nose and about 2 cm. below the right eye. From here it has extended to the bridge of the nose in a mesial direction, and as far laterally as the corner of the mouth, and reaching from this point to the lower border of the right eye.

The seat of this lesion is entirely upon the location of the original eruption eleven years ago. Within the past nine weeks a lesion measuring about 6 cm. has appeared upon the abdomen near McBurney's point. About seven weeks ago another lesion, measuring about 4 x 8 cm., appeared on the anterior surface of the right thigh, and within the last three weeks two more lesions, which now measure about 3 cm. in diameter, have appeared in the left inguinal region. The later eruptions have the appearance of fungoid excrescences and are raised above the surrounding tissues from 2 to 5 mm. Looked at from above they have the appearance of a cauliflower mass that has been tightly compressed. For the most part the surfaces of the excrescences are quite flat and even, those on the abdomen are less so and are sunken and irregular in the center.

The older eruptions have less elevation than the more recent ones, but all are distinctly elevated. The color of the later eruptions is light red with a tinge of purple. The one on the face is brownish. They are firm to the touch. Those on the thigh and the neck are very sensitive and painful; those on the neck itch. The others are not painful. About the margin of the eruptions on the abdomen is an area about 1 cm. in width which is dark and angry looking. About the one on the thigh this is less marked; and about the older ones still less so. The original eruption on the face eleven years ago began as a black pimple, with a history of but little discharge. The eruptions on the breast, the thigh, and the abdomen began, in the patient's own words, as "small swellings having a covering like tissue-paper," which broke with discharge of fluid. From time to time crusts have appeared which have dried up and fallen off. At present the application of an oily preparation seems to prevent their formation. There is little oozing. At times there is some fetor. The inguinal glands are not enlarged. The epitrochlear glands are not palpable.

During the past two weeks there has developed anesthesia to touch and pain and some paresthesia in the ulnar region of the right hand, extending from the wrist to the tip of the ring and little fingers. There has developed within the same time tenderness with rheumatoid pains, over the entire left tibia. The patient has borne fifteen children with the following histories: The first died at twelve years of "heart trouble;" the second, at fourteen months, cause unknown; the third is living and well, twenty-eight years old; the fourth died at eighteen years, of "consumption;" the fifth, at sixteen years of "consumption;" the sixth is living and well; the seventh is living and well; the eighth died at six

weeks, cause unknown; the ninth died at eighteen weeks, cause unknown; the tenth is living and well; the eleventh is living and well, four years old, the youngest living; the twelfth died at two months, cause unknown; the thirteenth died at nine weeks, cause unknown; the fourteenth died at eight weeks, cause unknown; the fifteenth was still-born (the only miscarriage) three years ago, evidently near term.

There is no history of any sore-throat nor falling of the hair, nor any necrotic ulceration. The lesions have always appeared distinctly raised above the surrounding tissue. The husband came to this country one and one-half years before the wife, but reveals no history of sore-throat, falling of the hair nor eruption of any kind. The patient is well nourished, there being considerable excess of abdominal adipose tissue. She sleeps poorly on account of pain and for the past six weeks has had little appetite.

*Microscopical Findings.*—Histologically an epithelioma. Atypical epithelial cell-proliferation into the deeper tissues. Sections were stained for tubercle bacilli with negative results. Sections stained by thionin, methylen blue and klebs. Triple stain for protozoa, deeply staining bodies with hyaline rings in epithelial cell-masses, probably protozoa. A few organisms with double contour were present.

## CLINICAL MEMORANDUM.

### A NEW TRACTION HIP-SPLINT.

BY JAMES K. YOUNG, M.D.,

OF PHILADELPHIA:

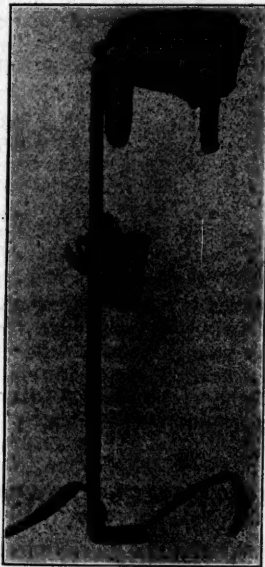
PROFESSOR OF ORTHOPEDIC SURGERY IN THE PHILADELPHIA POLYCLINIC HOSPITAL AND COLLEGE; CLINICAL PROFESSOR OF ORTHOPEDIC SURGERY IN THE WOMAN'S MEDICAL COLLEGE, ETC.

THE inefficiency of any original appliance is shown by the number of modifications which it has undergone. The long traction splint designed by Taylor and improved by Shaffer has in my hands proved so efficient that modification has seldom been necessary, but the splint here described has been the result of an effort to construct an appliance combining all the good qualities of the better class of long traction splints in a cheaper form. The writer calls it his "Poly-clinic hip-splint."

A piece of light gas-pipe is substituted for the hollow steel tube which is ordinarily used for the upright of the splint. Into the upper portion of this a piece is brazed, and perforated so as to attach it to the pelvic band by a heavy screw and two nuts. The waistband is the same pattern as that employed in the more expensive apparatus but of less expensive material, consisting of a band of sheet steel, covered with leather and well padded, with buckles for two perineal straps, and a leather strap completing the circumference. Into the leather end of the tube is inserted a forged foot-piece, the upper portion of

which is cut with threads for two nuts, and the lower end has attached to it a piece of sole leather and a strap to buckle into the leg extension adhesive straps. The foot-piece should be prevented from turning by a screw working in a slot in the front part of the tube. The thigh pad is attached to the upright tube by a sliding steel arm made adjustable with a side screw and having four

FIG. 1.



The Polyclinic Hip-splint.

buckles. The tube may be fixed at any angle upon the pelvic band by means of the tube nuts, and extension may be made from the lower end of the tube by the two nuts.

This brace has been used by the writer for the past two years in dispensary practice and has proven itself cheaper than, and equally efficient with, the more expensive apparatus. It should be used with crutches and a high shoe.

229 South Sixteenth Street.

## MEDICAL PROGRESS.

**Permanent Artificial Anus.**—R. F. Weir (*Med. Record*, April 21, 1900) describes a method of making an artificial anus which is under full control, even to the extent of preventing the escape of gas, and without the use of cumbersome apparatus. The gut is made to come out through the usual opening inside the iliac crest. The lower end is completely severed, closed by sutures, cleansed and dropped back into the abdominal cavity. For the upper portion a canal is made by separating the layers of abdominal muscles out to the iliac crest, where the fascial attachments are divided, and the canal continued sub-

cutaneously to a point two inches behind and one inch below the anterior superior spine, where a second skin incision is made. Through this canal the upper portion of the gut, cleansed and closed, is pulled and sutured to the skin incision just mentioned. The skin incision inside the iliac crest is then closed. The bowel may be kept closed for twenty-four hours to prevent soiling before adhesions occur. No apparatus is necessary. A piece of gauze is laid over the opening and the weight of the clothing gives pressure enough to occlude the bowels as it passes over the crest of the ilium. In certain cases it is necessary to cut the mesentery a little to render the gut sufficiently movable to reach the extra-iliac incision and this cutting does least damage to the arterial supply, when the line of division is parallel to and one and one-half inches distant from the gut.

**Castor Oil for Neuralgia.**—Neuralgia and tic-douloureux are painful disorders which are often very obstinate and unyielding to any treatment. Harold N. Moyer (*Jour. Am. Med. Assoc.*, April 21, 1900) reports some brilliant results from the use of castor oil in these affections. He has treated about fifteen cases of neuralgia by this method, but only seven of these are reported. Of these seven cases, five were facial, and two were brachial neuralgias, and only one case failed to improve under the administration of the castor oil. One of the cases of brachial neuralgia was very severe, and various remedial measures had been employed without result. This patient was given a large dose of castor oil at noon, three hours later the pain had greatly decreased, and the following morning it had disappeared entirely. The patient took several more doses of the oil, but the pain did not return. Two weeks' treatment with castor oil cured an acute case of facial neuralgia. In one case of tic-douloureux, which had lasted for 17 years, the administration of the oil was followed by an immediate improvement of the pain. The spasms continue and there are occasional twinges of pain, so that the patient cannot be said to be cured, but the pain is so much less severe that the patient is more comfortable than he has been in years. Another case of facial neuralgia, which had lasted for five or six years, was cured at the end of one week of the castor-oil treatment and there has been no return of the pain. Six doses of castor oil cured a supra-orbital neuralgia, which had lasted for nearly fifteen years. In the case which was not benefited by this treatment, a mixed astigmatism and well-marked eye-strain were discovered. The writer administers the oil in from one- to two-ounce doses every morning before breakfast until relief from the pain is obtained. The oil should be "washed" and a few drops of essence of anise added to each pint. The best method of taking the oil is to stir it up in a tumbler with two or three tablespoonfuls of ale. He recommends Dogshead or Bass' ale, as they contain a large quantity of gas, and says that if the



oil is taken in ale thus, it makes an emulsion with the ale and cannot be tasted. After the first doses the oil seems to lose a good deal of its cathartic power. The writer does not explain how castor oil acts in relieving neuralgia, but says that it is not due to its cathartic action. He discusses briefly the physiologic action of the drug, which is not as yet definitely determined.

**Intermenstrual Dysmenorrhea.**—The phenomenon of intermenstrual dysmenorrhea, if mentioned at all in text-books, is stated to be rare. Malcolm Storer (*Bost. Med. Surg. Jour.*, April 19, 1900) has observed this phenomenon in no less than 20 out of 400 cases. He presents notes of 20 cases of his own, and on these and 25 additional cases collected from literature, he makes the following observations: (1) The pain appeared with regularity in all the cases, practically every month except when pregnancy was present. In 22 cases the pain always occurred on a certain day from the beginning of the last menstruation. There was a variation in 13 cases of two days, and in 4 of four days. In 2 cases of irregular menstruation it appeared on a certain day before the beginning of the next menstruation. (2) In 37 out of 41 cases the pain appeared on from the twelfth to the sixteenth day, counting from the first day of the previous menstruation. In 20 cases it appeared exactly on the fourteenth day. In 2 cases it began on from the seventh to the tenth day, in one on the seventeenth, and in one on the eighteenth day. (3) The character of the pain was paroxysmal in a large number of cases, the attacks coming either at intervals of several hours, or else there was a constant pain with marked exacerbations, subjectively much like labor pains. The pain resembles that of menstruation in about one-half of the cases; in the others it was "entirely different." (4) The pain reached its maximum on the first or second day, and lasted in 10 cases two days, in 9, three days; in 8, one day, and in only 4 did it last four or more days. (5) The site of the pain in 14 cases was limited to one side, in 2 it alternated, and in 12 it was more general. (6) The pain was not accompanied by a discharge like that of menstruation in any of the cases. For this reason the writer objects to the term "intermenstrual dysmenorrhea." In 10 cases, however, there was a marked increase of leucorrhea, indicating congestion. In considering the etiology of this pain, Storer discusses the following theories which have been advanced: (1) The mechanical theory—tubes, ovaries; (2) the neurosis theory; (3) the intermenstrual cycle of congestion theory; (4) the intermenstrual cycle of ovulation theory. Not believing any of these theories to be entirely correct, the writer offers the following theory which he calls the "awakening of menstrual activity" theory. This intermenstrual pain comes on about the fourteenth day after the beginning of menstruation, which is the nineteenth after the climax of Stephenson's wave. Therefore it occurs just about

the time the pressure line has reached its lowest point. If we then suppose that the intermenstrual wave, if one exists, is one of preparation rather than of subsidence, in which nature, suddenly awakening, begins to make ready for the coming activity, whether menstrual or ovarian, the readjustment of forces might account for the occurrence of this pain. This theory, the writer thinks, would not be incompatible with the fact that this pain occurs under such a variety of pathological conditions. He cites several cases showing that the pain has more relation to the coming menstruation than to the previous one.

**Intestinal Suture.**—W. Edmunds and E. C. Stabb (*Lancet*, April 14, 1900) performed experiments in circular enterorrhaphy. They used three different methods: Halsted's inflated rubber cylinders; Murphy's button; and Laplace's forceps. Seven trials of each method were made on dogs. All cases by the Halsted method were successful, only five by the Murphy button, and four by the Laplace forceps. The inflated rubber cylinder pushes back the mucous membrane which otherwise always interferes with suturing the outer coats, especially the peritoneum. At the same time it prevents the outflow of intestinal contents so that no clamps or ligatures are necessary. Murphy's button is not always trustworthy unless reinforced by external sutures, the placing of which lengthens the operation materially. Recovery is not so rapid after Murphy's button. After Halsted's method formed stools appeared next day; after Murphy's button formed stools occurred only after three or four days. Laplace's forceps are of little assistance.

**Dormiol as a Hypnotic.**—In order to satisfy all the requirements of a good hypnotic, a drug must be effective in all cases of insomnia irrespective of cause; it must be cheap, of fair taste and unaccompanied by sequelae. R. Peters (*Münch. med. Woch.*, April 3, 1900) thinks the dormiol satisfies all these requirements to a high degree. It is a combination of chloral and amylenehydrate, occurring in form of an oily, camphoraceous liquid which can readily be given in capsules or in form of a ten-per-cent. aqueous solution. In the sleeplessness of functional and organic nervous diseases, as well as in pulmonary, cardiac, intestinal and nephritic lesions, its action has been uniformly good. After doses of 7.5 grains a more or less deep sleep will follow in one-half to one hour, and it is but seldom necessary to increase the amount up to 15 to 30 grains. As in other hypnotics, a certain degree of tolerance is established after a while.

**Infantile Diarrhea.**—W. E. Fothergill and J. Penny (*Med. Chron.*, April, 1900) report the observations on 71 cases of infantile diarrhea appearing in dispensary practice; 11 cases died, the remaining 60 recovering on salol or petroleum alone, the diet being an ordinary one suitable to the child's age. Salol was given in powder in 36 cases; half a grain every three hours was the min-

imum dose and three grains every four hours, the maximum dose. Salol did not allay the vomiting and even proved irritant in many cases. The cough which so frequently is present was not appreciably influenced. Salol was, therefore, found to be a valuable intestinal antiseptic, but should be given to children not more than once or twice daily, and mixed with some demulcent. Petroleum was used in 34 cases, the preparation being an emulsion containing 33 per cent. of petroleum. The usual dose for child one year old was one dram three times per day. In all but two cases the results were satisfactory. No derangement of stomach was noticed, the vomiting usually stopping before the diarrhea. The movements rapidly resumed their normal smell, color and consistence. The bronchial catarrh was obviously improved in many cases. It is not probable that petroleum undergoes much change in the system since nearly all of it can be recovered in the feces. Bismuth may be combined with the above and calomel or hydrarg. cum creta seem to act better when followed by a few doses of petroleum.

**Continuous Use of Digitalis.**—J. Groedel (*Practitioner*, April, 1900) discusses the conditions of the heart in which he believes a continuous use of digitalis is sometimes indicated. He believes firmly in the physical and dietetic method of treatment of chronic disorders of the circulation, but urges the benefits derived from digitalis in many cases where internal medication is necessary. In the majority of heart diseases there comes a time when lasting compensation cannot be produced by rest, baths, gymnastics, or short courses of medicines. He believes that, instead of waiting for symptoms of incompetence, such as diminished diuresis, accumulations of fluid and dyspnea, it is much better to use digitalis at regular intervals, say four to eight grains one day a week or perhaps less frequently. In this way compensation may be preserved for a long time, and although finally the effect is lost and death results, yet the comfort of the patient is much enhanced in the meantime. Although the cumulative effects of the drug are to be avoided, the author has seldom seen a well-marked case of toxic symptoms referable to the heart. Secondary effects, such as nausea and flashes before the eyes, are more frequent and act as warning signals, especially when the pulse becomes irregular after only small doses. By observing diuresis dangers of cumulation may be avoided, for, if the urine is not increased after its use for several days, the drug must be stopped. The assertion that digitalis produces a rapid decline of strength is denied by the author who claims that this is due to the disease for which digitalis is taken. He further believes that the body does not become inured to the remedy and thus less effected by its administration. Mitral insufficiency is the lesion which is naturally most benefited by digitalis, but he believes that no entire class should be excepted, especially when no contraindications,

such as great tension or an individual repugnance, exist. In cases of slight fatty degeneration in which the muscle is still capable of repair, continued use of digitalis oftentimes proves successful.

#### **Constitutional Causes of Catarrhal Affections.**—

Catarrhal conditions of the upper air passages are so common and their treatment oftentimes so unsatisfactory, especially in this climate, that it is extremely important to discover the underlying cause which predisposes to the local condition. W. A. Wells (*Med. Record*, April 21, 1900) gives a valuable résumé of the constitutional affections which are liable to cause these catarrhal lesions and the treatment which he has found most successful. He believes that the local trouble may be considered secondary to the systemic disease when: (1) No adequate local cause is apparent; (2) direct local treatment has failed; (3) the catarrhal inflammation has manifested itself after the coexisting trouble; (4) catarrhal inflammations appear in other parts of the body; (5) the supposed cause is sufficient to produce these local effects; (6) and when treatment of the associated condition improves the local catarrh. It is believed that cutaneous eruptions, such as herpes, urticaria and pemphigus may appear as true reflex neuroses of nasal origin and on the other hand may act as the primary cause of the nasal trouble. The gastro-intestinal tract is, no doubt, responsible for much of the nasal catarrh and he recommends a careful consideration of it in all obstinate cases. Pepsin, hydrochloric acid and nux vomica are often very effective when given after meals. Intestinal obstipation is important and is most satisfactorily relieved, according to some authors, by sulphur. Intestinal flatulence is best relieved by regulation of the diet, massage and exercise, combined, if necessary, with such medication as: pepsini pur. and pancreatin ext., aa gm. ii; pulv. carb. liq., and bism. subgallate, aa gm. iv. M. Fl. chart. xii. S. One before meals. Cardiac lesions frequently cause a local engorgement and must be carefully examined for. Movable kidney and affections of the reproductive system of the female are sometimes responsible for sympathetic conditions in the nose and throat. Hysteria often aggravates a local inflammation and while topical treatment is being employed the hysterical state is perhaps best influenced by such methods as electricity, balneology, change of environment, and separation from too sympathetic friends. The gouty or neuro-arthritic diathesis no doubt plays an important rôle in many obstinate throat conditions and has fairly characteristic manifestations. The soft palate, fauces and posterior walls of the pharynx present a highly engorged condition approaching bagginess. Intense redness, pain in throat, difficulty in swallowing and soreness in the cervical muscles are usually present. The larynx becomes involved and gouty deposits are found in the crico-arytenoid joints and the true vocal cords. Locally, thiol, two to four per



cent. in glycerin, is valuable, but the general condition must be improved by the salicylates, iodides and the alkaline treatment. Stress is also laid upon the sympathetic diathesis by which is meant the disposition to the origin of reflex disturbance in various parts of the body, shown so frequently by the attacks of hay-fever, migraine and asthma, etc. Too much importance oftentimes is attached to the local condition, the underlying morbid state, due probably to a vasomotor causation, being overlooked. The sedative or motor depressant drugs are most in vogue, such as bromides, opium, chloral, amyl nitrate and nitroglycerin. For hay-fever, in addition to the local treatment, he recommends:

R Zinc phosph. .... gr.  $\frac{1}{10}$   
 Quinine sulph. .... gr. ij  
 Ext. belladonnæ .... gr.  $\frac{3}{8}$ .

S. One pill before each meal.

Neurasthenia, no doubt, oftentimes prepares a ground of such sensitiveness that a minimum change shall give rise to maximum symptoms. Rest, massage, electricity and change of environment are important. The glycerophosphates perhaps are the most efficacious drugs for internal medication in neurasthenic cases.

**Purulent General Peritonitis.**—F. Bode (*Mitt. aus den Grenzgebieten der Med. u. Chir.*, 6. Band, p. 286) says that the general peritoneal cavity is roughly divisible into four cavities, an upper, from the hollow of the diaphragm to the level of the navel where the anterior abdominal wall closely approaches the posterior forming a strait, a right and a left cavity, comprising each iliac fossa and bounded internally by the anterior border of the psoas muscles, and, finally, an inferior cavity, comprising the true pelvis and the space above it between the two psoas muscles. The arrangement of the boundaries and contents of these spaces determine the natural walling off of abscesses within them from the general peritoneal cavity. Such occurrences are common in appendicitis, in diseases of the uterine adnexa, in those of the stomach, duodenum and gall-bladder, and furnish the first hint in the treatment, namely, thorough drainage of each cavity with reference to its usual boundaries in cases of general peritonitic infection. The second indication is the complete irrigation of the affected local or general peritoneal cavity with salt solution at the time of operation and thereafter by permanent irrigation, if necessary, both to wash away the exudate and to prevent undue adhesions. The hindering of these unnecessary adhesions is at least for a time provided for also by leaving considerable solution in the cavity at the operation. By such constant flow or frequently repeated flushing and a carefully planned drainage of one pocket into the others, the pus is mechanically removed and tends to settle in the depths of these four recesses whence drains take it to the surface of the body. The method of procedure is as follows: When the peritoneal cavity has been opened without respect to the light adhesions, all

the movable intestines are eventrated and washed and search for and treatment of the perforation or other cause of the disease made. Likewise careful attention is given to cleanse and dry all depths of the cavity, those of the pelvis, about the liver and spleen, etc. The quantity of solution is 30-40 quarts at a temperature of 105-115° F. Peristalsis is promoted and shock combated by the treatment, notwithstanding the manipulation. The eventrated intestines are next replaced. Then a long fenestrated rubber drain-tube is carried through the base of the mesentery, curved on itself along each side of the vertebral column and passes over the colon through a secondary opening in each flank. Other drains are carried through the lateral incisions into each iliac fossa and through the original median approach to the environments of the liver, stomach and spleen. Under continuous current of salt solution to drive out the air the incisions are narrowed by layer sutures as much as possible. The potency of all the tubes is tested. Copious dressings are now applied and the patient put to bed with head and trunk elevated to promote gravitation of the exudate downward to the drains. Then a thorough flushing out of all the tubes with 1000-1500 c.c. of warm salt solution was done two or three times daily, attaining cleanliness, stimulating peristalsis, promoting defecation, and preventing collapse. The results quoted are all good. Upon the cadaver irrigation through similarly arranged tubes with colored fluid was shown to be far-reaching and efficacious.

**Bacteriology of the Gall-Bladder.**—Dr. L. von Mieczkowski (*Mitt. aus den Grenz. der Med. u. Chir.*, 1900, p. 307) says that he has established the fact that in healthy animals the contents of the healthy gall-bladder, hepatic and cystic ducts are usually sterile, while those of the distal, i. e., intestinal, end of the common bile-duct are very commonly infected from the cavity of the duodenum. In man he has confined his observations to the gall-bladder during laparotomies. Here he finds sterility always present in health and even in cases of cholelithiasis not associated with inflammatory complications. The reaction of the bile was commonly feebly alkaline or neutral. He also found that fresh human bile is only imperfectly germicidal, permitting the staphylococcus pyogenes to proliferate rapidly and the bacillus coli communis almost unhindered. The normal sterility of the gall-bladder contents and of the proximal ducts may be explained by the force and direction of the flow, which sweeps back into the intestine any germs which may tend to invade more than the distal end of the common duct. When bile stasis in disease occurs, this cleansing current is stopped and germs promptly invade the proximal ducts and the bladder, especially the bacillus coli. Such cases of cholelithiasis as are sterile may be explained by the pouring out of sterilizing fluids into the bladder during the acute stage, which either totally or partially destroy the bacteria. Experiments with

animals also showed that fatal peritonitis occurred more often when the contents of the infected bladder were thick and imperfectly absorbable than when thin and more readily taken up by the lymphatics.

**Tannopin.**—There is a great advantage in combining tannin with other compounds which allow it to pass the stomach unaltered, but the effect is heightened if at the same time an antiseptic is set free. Tannopin or tannon, a combination of tannin with urotropin, is one of the most reliable of this group according to E. Doernberger (*Munch. med. Woch.*, April 3, 1900). Small children take doses of 7.5 grains without abdominal discomfort or other undesirable symptoms. It is necessary to continue the drug some time after the acute or chronic diarrhea has abated to guard against relapses. The only disadvantage is the expense.

**Cause of Xerosis Conjunctivæ.**—It has recently become the prevailing opinion that xerosis and keratomalacia are bacterial affections; a view supported by the fact that numerous micro-organisms have been isolated from the conjunctiva. M. Radziejewski (*Therap. Monatshft.*, April, 1900), however, thinks that the primary lesion is due to a nutritional disturbance which creates a *locus minoris resistentiæ* and thus explains the bacterial flora found. There generally is no uniformity as to the number and variety of bacteria present; thus in addition to the xerosis bacillus, streptococci, staphylococci, pneumococci and others have been encountered. As to treatment, in addition to tonics, frequent irrigations with chlorine water, hot poultices and the application of iodoform are recommended, with later the continued massage with yellow oxide of mercury ointment.

**Itrol in Diseases of the Skin.**—Not only in gonorrheal and other venereal troubles has this citric acid salt of silver given evidence of its therapeutic value, but also in affections of the skin is its worth highly lauded by O. Werler (*Wien. klin. Rundschau*, April 1, 1900). The methods of application of itrol are the following: (1) In a solution of 1-10,000 up to 1-4000 for wet dressings, irrigations, etc.; (2) in powder form; (3) as itroitalcum in one-half to five per cent strength; (4) in vaseline up to a strength of two per cent; (5) in pencil form in one to two per cent. strength, mixed with ol. cacao in a base of cera alba. Itrol answered in all cases where an antiseptic and disinfecting medium was called for. It acted in a mild, but efficient manner and was entirely harmless to the patient. No irritation of the skin followed its use. No idiosyncrasy for the remedy was discovered in any of the patients. It is only necessary to begin the use of itrol with small doses, gradually increasing them, to insure entire freedom from pain and a possible local irritation.

**Formalin Alcohol in Night-Sweats.**—At a meeting of the Berliner Medicinische Gesellschaft (*Berlin. klin. Woch.*, April 9, 1900), H. Hirsch-

feld read a paper on the success attained in phthysical night-sweats by the use of a mixture of formalin and alcohol. The method is as follows: A mixture of equal parts of formalin and absolute alcohol is applied by brush or cotton wad to those parts of the body subjected to the sweats. Caution must be observed, however, in order to prevent the patient from inhaling the formalin vapors; for should this occur, the breathing becomes oppressed, the nasal and pharyngeal mucous membranes become irritated, tendency to cough results, the eyes become inflamed and the patient is thereby made miserable. To prevent all this, Hirschfeld provides himself with gutta-percha tissue—about a square yard—which he wraps around the patient, the latter being covered only by an undershirt. This envelope is slightly lifted while the brush moistened with the formalin alcohol is applied to the back. Then the patient is told to lie on his back, the shirt and gutta-percha covering the chest and abdomen are raised, and the same application made here. It must be carefully done and all crevices where the formalin vapor might escape, e. g., about the neck or the waist, must be closed by means of cloths covered with the gutta-percha tissue. Then the patient is covered with the bed-clothes and remains so for one hour. After that time the formalin vapor has disappeared from the skin and the rubber tissue may be removed. When done thoroughly and carefully, not a trace of the vapor reaches either eye or respiratory apparatus. In some case, one such treatment is all that is necessary to prevent the sweats for many weeks. In others it happens that after two, three or four weeks a second procedure is called for. It is only in the most stubborn cases that a second or a third treatment within a week may be necessary. As for the power of the skin to withstand the formalin when applied over a course of some little time, Hirschfeld says that he met only occasionally with disagreeable results. Once, an urticaria; twice, slight erosions, and at times a scaling of the epidermis were the chief effects. He now paints the back, chest and abdomen in one sitting, leaving the arms and legs for another. It is to be observed that the formalin is not to be applied to parts which may have wounds or erosions; nor to parts which have recently been covered with mustard plasters or painted with iodine; nor to the nipples and navel, the genitals and the arms. A slight burning sensation follows the application of formalin, especially in delicate skins. Such cases should be treated with a weaker solution of formalin than ordinary ones. Under no condition should the formalin be entrusted to the patient's care or use. Grave results can be occasioned thereby. The final words to be said for formalin are: (1) It is superior to all other antidirotics in its certainty of action and its promptness; (2) in the length of time over which it produces its effect; (3) all other remedies are superfluous. There is no doubt in Hirschfeld's mind that formalin has gained a high point in phthisiotherapy.



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SATURDAY, APRIL 28, 1900.

## THE CONGRESS OF AMERICAN PHYSICIANS AND SURGEONS.

BEFORE the appearance of our next issue the Fifth Triennial Session of the Congress of American Physicians and Surgeons will be held in Washington. The program of this session has been more wisely arranged than formerly in that it is designed to attract the members of the constituent societies to the meetings of the Congress. Instead of an effort to present elaborate, epoch-making theses, the general subject of "Bacteriology in Health and Disease" will be presented in its various aspects by a series of short papers. This is eminently wise, as it gives great variety to the program and adds to the interest by the number of speakers that will appear.

The first session of the Congress, which will be held Tuesday afternoon, will be occupied by this discussion, while that of Wednesday will be devoted to two addresses on topics of general interest, and a poem by Dr. S. Weir Mitchell. In the evening of that day Dr. Henry P. Bowditch will deliver the presidential address upon "The Medical School of the Future."

The programs of the constituent societies set forth a veritable feast of medical lore and dis-

cussion. More time than formerly will be allowed these, the meetings of the Congress being limited to the two sessions of Tuesday and Wednesday afternoons. The social functions have not been neglected, and invitations to private dinners, luncheons, etc., will reach their climax in the banquet on Thursday night. The MEDICAL NEWS of May 5th will present a complete but concise report of the entire meeting, together with some of the most important addresses and essays.

## PROPHYLAXIS OF CHILDREN'S DISEASES.

WE are getting ever farther and farther away from the idea, once so prevalent, that the so-called "ordinary diseases of childhood" are practically inevitable. While the most careful precautions are necessary to prevent the spread of measles, scarlet fever, and whooping-cough, the problem of their prophylaxis is by no means hopeless of solution. School inspection has in recent years made it clear that the prevention of the spread of infectious disease among the children of a neighborhood is only a matter of exact segregation. It remains now for the family to demonstrate that even when a contagious disease has entered a household, it is by no means a foregone conclusion that all of the susceptible members will be attacked. This is already a happily accomplished fact in the practice of many physicians.

It has been often said that scarlet fever is intensely contagious. It is true that the germs of the disease retain their virulence for a long time and outlive seemingly unfavorable conditions, such as long transportation in letters. The disease does not spread, however, except by direct contact with material from a scarlet-fever patient. As for whooping-cough, attention has been called in France to the fact that the mere separation by the corridor of a hospital of those suffering from the disease, and the prohibition of the passage of attendants from an infected to an uninfected ward are sufficient to prevent the spread of the disease. In measles segregation precautions to be effective must begin early and must be very carefully enforced. Even against its eminent contagiousness, however, a barrier can be placed much more effectively than formerly because of the help that Koplik's spots afford in the early diagnosis of the disease.

All of the diseases of children are worthy of respect in this matter of prophylaxis. Even mumps and chicken-pox may give rise to compli-

cations in the joints, kidneys or heart, that will seriously interfere with subsequent good health, and make the patient much less resistant to disease later in life.

Now that schools are becoming less a factor in the spread of contagion, the physician himself must take additional precautions that he, in the course of professional work, does not prove a source of contagion. The practice of wearing a long washable overgarment while attending cases of contagious disease is no longer merely an extraordinary precaution to be taken in better class families. It has become a plain duty for the physician in all cases. Children can, without doubt, be guarded effectively from all contagion until such time as their resistive vitality will protect them. Freedom from the contagious diseases of childhood will often mean perfect health for the individual up to adult life, while, as is well known, these diseases often leave their "marks" on developing adolescents. Damaged constitutions result that prove an easy prey to typhoid or pneumonia or insidious tuberculosis.

**THE AMERICAN MEDICO-PSYCHOLOGICAL  
ASSOCIATION AND THE PATHOLOGICAL  
INSTITUTE OF THE NEW  
YORK STATE HOSPITALS.**

If we give a rapid but critical glance at the vast field of psychiatry, we are struck by the significant fact that but few epoch-making works commensurate with those presented in other fields of enquiry are to be found. In the progress of physiologic, biologic, psychologic and medical sciences, psychiatry and especially psychopathology, that is, the science of abnormal mental life in general, have no doubt had their share, but that share is small, compared to that of other sciences. General laws, the essence of all science, are conspicuously absent in the province of psychiatry and a well-established and generally-accepted theory guiding psychiatric practice is as yet unknown.

What may possibly be the cause of this lagging of psychiatry behind all other sciences? Is it that psychiatrists care not for scientific progress? Is it that psychiatrists do not realize the modern point of view that theoretical science is an indispensable requisite of applied science? To these questions the answer must be favorable to the profession. The psychiatrists do care for scientific progress and do realize the importance of theoretic research work. Where then lies the cause of the slowness of psychiatric progress?

It lies partly in the extreme complexity of the science and partly in the lack of organized scientific investigation to work out results that are otherwise inaccessible to individual efforts. Psychiatry is far more complex than all other medical sciences, because, in addition to physical processes, psychic activities and their symptoms must be investigated. It is from this standpoint that more united efforts are required to make a successful start on new lines of research. What still more retards the growth of psychiatry is the fact that, although being the most complex of all medical sciences, it lacks central laboratories for special scientific research. And when such a laboratory is accidentally established with some degree of success, an asylum superintendent, who has but a faint conception of scientific work and of the spirit of toleration, tries to lay violent hands upon it and suppress it.

In our country, in the State of New York, a research center, the Pathological Institute was established for investigation of insanity along many lines of research. Instead of having the support of all interested in psychiatry, asylum superintendents in the function of commissioners, committeemen and hospital managers have been first and foremost in attempting to cripple it and stifle the very spirit of its work.

We must not, however, accuse all psychiatrists indiscriminately. For after all such destructive tendencies are confined to but a small portion of the profession, a portion that is used to authority, to order about, to command and to dictate. Unfortunately, science cannot be directed by mandates and ordered about. Science flourishes in freedom.

The issue now is, shall psychiatry be independent or shall it move, live and do the bidding of commissions, committees, and asylum managers? The question is a vital one. For it means the life of psychiatry as a science; it means the life of psychiatry as an American cultivation. It is to the honor of the United States that such an institute of wide scope was first established on American ground. Will the American Medico-Psychological Association permit an outrage on psychiatry in general and on American psychiatry in particular? Will the American Medico-Psychological Association let the reproach fall on it that it witnessed with equanimity, with indifference, the destruction of a psychiatric institute without raising even as much as a protest in its defense? The American Medico-Psychological Association, if we understand it aright, is for the



maintenance of the interests of psychiatry; it is, moreover, the guardian of American psychiatry. Will not then the Association stand firmly by psychiatry as a science and deprecate and denounce all those who want to regulate psychiatry by mandates, edicts and bulls? Will the psychiatric profession and the American Medico-Psychological Association in particular let the charge fall on it that it permitted scheming personalities and unrestrained individual jealousies to undermine a scientific research center of much promise, a center which European authorities recommend to their own countries as a worthy model?

## ECHOES AND NEWS.

### NEW YORK.

**Hospital for Sick Animals.**—The Commissioners are constructing a hospital in connection with the Central Park menagerie for sick animals. The hospital is designed more especially for sick deer, but a part of it will be set aside for the feline species.

**Crusade against Spitting.**—Dr. Robert A. Black, chief of the Health Department of Brooklyn, has begun active steps in enforcing the law against expectorating on the floors of public buildings, ferry-boats, or street cars. Two men were arrested April 11th on the street cars for spitting upon the floor. The penalty for breaking this ordinance is a fine ranging from \$1.00 to \$250.00. An arrest was also made the same day upon the Third Avenue Elevated Road.

**Gift to Mt. Sinai Hospital.**—Meyer Guggenheim and his sons have given \$200,000 to Mount Sinai Hospital. The money is to be used to erect a hospital building in the group to be built in Fifth Avenue between One Hundred and One Hundred and First Streets. The new building will be erected as a memorial to the deceased wife and mother of its donors. The structure will be set apart solely for private patients.

**Nicoli Dead.**—The acrobat Nicoli, who, in attempting a triple somersault in one of the New York theaters last week, fell and dislocated one of his cervical vertebrae, died April 23d. An operation was performed at Bellevue Hospital to relieve the pressure made upon the cord by the sixth cervical vertebra, and it was believed at one time that the patient would recover, but he gradually succumbed.

**Anthropology at the Barge Office.**—Professor Ripley and ten post-graduates at Columbia University made a descent recently upon the Barge Office (immigrant quarantine) in search of interesting specimens. Their careful measuring of skulls and their fluent talk concerning the Retzius principle of measurement of dolichocephalic,

brachycephalic, and mesocephalic craniums created no little excitement among the bewildered immigrants.

**Contagious Diseases.**—For the week ending April 12, 1900: Measles, 716 cases and 27 deaths; diphtheria, 240 cases and 55 deaths; laryngeal diphtheria (croup), 18 cases and 5 deaths; scarlet fever, 176 cases and 18 deaths; chicken-pox, 14 cases and no deaths; tuberculosis, 201 cases and 182 deaths; typhoid fever, 7 cases and 3 deaths; cerebrospinal meningitis, 10 deaths; totals, 1372 cases and 300 deaths.

**Dr. Jacobi Honored.**—A number of friends, professional associates and admirers of Dr. Abraham Jacobi have arranged to celebrate his seventieth birthday by giving him a dinner at Delmonico's on the evening of May 5th. This is recognition of the high esteem in which Dr. Jacobi is held personally and of the valuable services he has rendered in various relations during the course of his career of almost fifty years as a physician, educator, and civic worker. In accordance with a long-established German custom, it is the intention of those having the matter in charge to publish a "Festschrift," that is, a series of papers by representative men, setting forth the present status of science in the various departments of medicine. The affair is not exclusive in any particular; application blanks for a seat at table can be secured by addressing Dr. A. G. Gerster, Chairman, P. O. Box 3032, New York City.

**New Genito-Urinary Organization.**—A number of the leading genito-urinary specialists of this city have formed a society to be known as the New York Genito-Urinary Society. It will meet monthly, when cases will be reported and papers read on different branches of the specialty. The office-bearers are: President, Dr. Ramon Gutierrez; Vice-Presidents, Drs. Winfield Ayres and Otis K. Newell; Treasurer, Dr. George W. Blanchard; Secretary, Dr. A. D. Mabie; Corresponding Secretary, and Stenographer, Mr. Samuel Bennett, 161 Garfield Place, Brooklyn, from whom information as to terms of membership, etc., may be obtained. Correspondence is invited with specialists in other parts of the country and abroad.

**Ambulance Wrecked.**—A Flower Hospital ambulance, while making a hurry call recently, was wrecked at Third Avenue and Fifty-Eighth Street. The driver, Frank McKenna, and Dr. Peckham, the surgeon, received various scalp and other wounds. They were taken back to Flower Hospital in an ambulance from the Presbyterian Hospital.

**Obituary.**—Dr. John Habershaw died on April 20th in his forty-sixth year. He was graduated from the College of Physicians and Surgeons and was in active practice. He was widely known socially.

**Bellevue's Interpreter.**—Joseph Klovetschek,

who was killed on Park Row on April 21st, was unofficial interpreter at Bellevue Hospital. A German by birth, he spoke French, Spanish and Italian, and enough of many Eastern dialects to make himself understood. Greeks, Armenians, Arabs and even Chinamen made themselves intelligible through him.

**Hot Air in Bellevue.**—The Sprague apparatus for the treatment of rheumatism, sciatica, etc., has been placed in Bellevue Hospital. Air heated to a temperature of 400° F. can be applied to the whole body, while there is a separate apparatus for a single member. Until now the hot-air treatment has been applied at Bellevue by means of a simple thermostat manufactured on the premises. By this means only a comparatively low temperature could be secured. The hot-air treatment is a modification of the Turkish bath, the great advantage of the former being the non-respiration of the heated air by the patient and the consequent possibility of securing a much higher temperature. The present apparatus permits the patient's head to be uncovered and also allows of frequent moist applications to the forehead.

#### PHILADELPHIA.

**Bequests.**—By the wills of Mrs. Rebecca Emslie and Mr. George W. Miles, which have lately been filed, over \$130,000 has been left to the various hospitals and charitable institutions of the city.

**Home for Incurables.**—The J. Lewis Crozer Home for Incurables at Chester has recently been dedicated. The building has accommodations for 160 patients. Dr. D. P. Maddox has been appointed chief surgeon.

**Episcopal Hospital.**—A new nurses' home, four stories in height, has lately been added to the hospital facilities. The building contains more than 80 rooms.

**Tuberculosis Meeting.**—The annual meeting of the Pennsylvania Society for the Prevention of Tuberculosis was held April 11, 1900, at the Academy of Natural Sciences, Philadelphia. Dr. Guy Hinsdale was elected president and Dr. Alexander H. Davisson secretary.

**Health Report.**—Deaths in the city for the week ending April 21st were 739, an increase of 48 over the previous week and 234 over the corresponding week of last year. Contagious diseases: Diphtheria, 71 cases, 15 deaths; scarlet fever, 62 cases, 10 deaths; typhoid fever, 77 cases, 14 deaths. There were 31 deaths from influenza.

**Physician's Life Threatened.**—Dr. Charles Shaffner narrowly escaped injury at the hands of an insane woman last week. Five shots from a revolver were fired at him, but luckily none of them took effect. The woman appears to have been plotting the deed for some months, testifying that voices from Heaven had commanded this action.

**College of Physicians.**—The Section on Gynecology met April 19th. Dr. C. P. Noble reported two cases of epithelioma of the vulva. He has had but four cases, three of which have died. The fourth, a woman aged sixty-three years, has now lived nearly two years after operation with no signs of recurrence. If the case is seen early enough for operation he advises wide excision of the parts and a dissection of the chain of lymphatics, and their including fatty tissue, which leads up to the groin as well as the glands of the groin itself.

Dr. M. O'Hara, Jr., demonstrated an anastomosis forceps which is exceedingly simple in its construction and working. The instrument consists of two pairs of long-bladed forceps which can be fastened together by a serre-fine clamp. The forceps are applied one on each side of the portion of intestine to be resected, the resection made, the forceps approximated and fastened together, and the ends of the intestine united, preferably by mattress sutures. The advantages claimed are: The rapidity and ease with which an anastomosis can be done; the lessened risk of after contraction; the cavity of the bowel is not exposed at any stage of the operation, thus limiting the risk of infection.

Dr. R. G. Le Conte reported two cases. One was the removal of a multilocular ovarian cyst weighing 32 pounds, six weeks after the patient had passed through normal labor. The second case was one of traumatic rupture of a dermoid cyst. The patient had suffered from pain in the back and abdomen for a period of four years. After a severe fall upon the right side of the abdomen, increased pain was felt and bloody urine was passed. A fibroid mass was felt at the right side of the vagina. Abdominal section revealed the presence of an oily fluid in the peritoneal cavity and a greatly thickened omentum. Matted hair, part of a jaw-bone, teeth, etc., were found. The sac of the cyst was adherent to the ovaries, uterus and rectum.

#### CHICAGO.

**Presbyterian Hospital Fund.**—The Easter offerings of eighty churches of the Chicago Presbytery were devoted to this fund. Nearly the whole of the amount desired, \$20,000, was raised. The greater part of this sum will go toward the expenses of electric lighting and a sterilizing plant.

**Vital Statistics.**—During the week ended April 14th there were 558 deaths reported in this city, this being 14 fewer than the preceding week, and 21 fewer than during the same week of 1899. It is noted, in comparing the past week with the corresponding period of 1899, that fewer children but many more aged persons are dying this year. The mortality of those under 5 years of age amounted to 134 last week, while one year ago 200 died at this age, a decrease of 66 for the week. During the past week the mortality of those over 60 years of age was 142, as against



115 for the corresponding week of 1899, or an increase of 27 for the week just ended. Pneumonia continues to be the principal cause of death, there having been 127 cases recorded during the week. Deaths from influenza numbered 27 during the week, the largest number from this cause for any week this year. There was only one death from scarlet fever, the lowest on record since the week ended Jan. 1, 1899.

Out of the 4138 pupils examined during the week, 251 children were excluded.

**Quinine as an Oxytocic.**—At the meeting of the Chicago Medical Society, held April 18th, Dr. Gustav Kolischer presented notes on some points in obstetrical practice. Attention was especially called to the diagnosis, treatment and position of the mother in cases of anterior vertex presentation, as the pelvis is in this condition frequently malformed, giving rise to serious complications. According to statistics, this condition is met with in from 8 to 10 per cent. of all confinements. The author believes in the effectiveness of quinine, which does not produce nor increase the pains, as is believed by so many, but, on the contrary, is extremely effective in regulating the pains and making them less exhaustive to the patient.

#### GENERAL

**Fate of the Hospital Ship "Missouri."**—The board of officers from Washington who have been inspecting the hospital ship "Missouri," have recommended that she be turned over to the Quartermaster's Department for use as a freight ship.

**Folding Bed Fatal.**—Dr. A. B. Allyn, a prominent physician of Chadron, Ohio, has died of injuries received recently by being shut up in a folding bed.

**Canned Meat for Soldiers.**—War Department officials have been compelled to resort to the use of canned roast beef for subsistence of the army in the Philippines. This is due to the fact that it is absolutely essential that the soldiers shall be served with fresh meat and because of the impossibility of providing refrigerated beef or cattle on the hoof under existing conditions.

**Abuse of Red Cross Privileges.**—A dispatch from Pretoria announces that when the so-called ambulance corps recruited in Chicago for service with the Boer Army reached the Transvaal capital, half the members of the organization immediately enlisted, and, tearing off their Red Cross badges, accepted the Mauser rifles provided for them by the pious burghers. Consul Hay immediately expressed his disapproval of this episode to the Boer Government and informed it that he would report its details to his superiors in Washington. Such action on his part was eminently proper, and it is to be hoped that it will lead to the taking of effective precautions against any further abuse of Red Cross privileges. The Red Cross will find its future work seriously hampered if it permits men wearing its symbols to violate their pledges of neu-

trality, and to use its immunities as a means of aiding one belligerent against another.

**Roentgen again Honored.**—The National Academy of Science, at its recent session in Washington, D. C., awarded to Wilhelm Conrad Roentgen, the inventor of the X-ray, the Bernard medal. This medal is presented only once in five years, and is given to the person making the most important scientific discovery during that period.

**Women Doctors Wanted in China.**—Mrs. Wellington White, a missionary doctor from China, made an impassioned address at one of the meetings of the Ecumenical Conference now in session in New York, and a fervent appeal for more women doctors in China. "Twenty years ago," she said, "when I went into the Province of Kwang-Tung, there were 40,000,000 people there, of which 20,000,000 were women, and not a woman doctor among them all, and the men would rather let their wives die than allow a man to cross the threshold to treat them."

**Examination for the Marine Hospital Service.**—A board of examiners will be convened at the Service Building, 378 Washington Street, New York City, Wednesday, May 23, 1900, for the purpose of examining candidates for admission to the grade of assistant surgeon in the United States Marine Hospital Service. Candidates must be between 21 and 30 years of age, graduates of a reputable college, and must furnish testimonials from responsible persons as to character. For further information, or for invitation to appear before the Board of Examiners, address Supervising Surgeon-General, United States Marine Hospital Service, Washington, D. C.

**The Plague.**—The reports from Honolulu, April 17, *via* San Francisco, announce that only one case of plague has appeared since the previous report, that of a half-caste girl, aged thirteen years, ending fatally. The cities Hilo and Kahului are pronounced clean of the disease. The steamer "Australia" was the first since the outbreak to leave Honolulu carrying steerage passengers for San Francisco. The vessel sailed April 17th. The sudden deaths of Filipinos and Chinamen in the Central Market at Manila have led to an investigation showing that fifteen cases of the plague, fourteen of which were fatal, have occurred within a week. The market is located in the center of the city. In black, rotten, wooden buildings, the keepers of the stalls live, with their families huddled together in great filth. Some of the victims were stricken and died within an hour. There have been several deaths in other sections of the city also which have been traced to infection from the market. Recently, after all the market people had gathered, the health officers threw a guard around the buildings, and will keep the inmates quarantined there for a fortnight. They will then burn the market. The total number of bubonic plague deaths thus far are 119 Chinamen and 66 Filipinos.

Last week we reported the appearance of the

plague at Aden; since that time there have been cases reported at several points on the Red Sea. Considerable alarm is expressed in Australia lest the bubonic plague be spread by the rabbits, and a commission has been appointed to investigate the possibility of rabbits, like rats, carrying the dread disease. A report that rabbits had introduced the plague into Northern Victoria caused a panic in that colony. Throughout India, during the week ending April 18th, the number of fatal cases of plague slightly decreased, but the aggregate was upward of 4,000. The famine continues a source of great distress. One district lost 1,000,000 cattle out of 1,300,000 head and almost numberless human beings were found dead from starvation. In addition, children were found wandering in all directions, homeless, naked, and emaciated, and cases were reported of children being sold. The official reports fully confirm the worst stories of the terrible nature of the distress. It is also announced that the natives are developing ugly feelings and are attacking Europeans. A great crowd of natives murderously attacked a party of soldiers at Shahpur, the military center of the Northwest provinces. The soldiers were rescued with difficulty and in an unconscious condition. The Viceroy of India, Lord Curzon, wires that the recent rainstorms have not improved the situation, that the demands for relief are increasing, now reaching 5,319,000 persons, but that the arrangements for relief are equal to the increasing strain. Over 5,000 bushels of corn will be shipped from the State of Kansas to the famine sufferers of India. The United States Navy Department has secured a five-thousand ton steamer to carry the food supplies collected in New York by charitable institutions to these plague and famine-stricken sufferers. A steamer has also been secured at San Francisco to carry similar supplies from that port.

**Divine Healer's Mail Held.**—Twelve sacks of mail addressed to Francis Truth, the "divine healer," who was arrested recently at Boston, charged with fraud, have been impounded by the United States Government under the usual "fraud order." Many of the thousands of letters contained in the sacks carry money for "absent treatment." Truth's usual charge was \$5 for absent treatment, so that necessarily the amount of money contained in the letters is very large. The twelve sacks of mail will be opened by the postal authorities. The letters which bear names and addresses on the envelopes will be returned with the money contained therein to the writers. The other letters will be sent to the Dead Letter Office at Washington to be opened.

**The "Maine" Reaches England.**—The United States hospital ship "Maine" arrived at Southampton April 23 from South Africa. Mesdames Adair, Ronalds, Blow, and others of the Hospital Ship "Maine" Fund Executive Committee, with Mr. Baker, President of the Atlantic Transport Company, intended to give a cordial and elaborate reception to the "Maine" and Lady Randolph

Churchill. A special steamer had been secured to take the party to the Solent to meet the "Maine" and escort her to the docks. But, to the chagrin of all, the hospital ship's early arrival frustrated the plans, and the committee, on reaching Southampton, found the "Maine" already berthed at her quay. She brought altogether 151 men and 12 officers. Fifty of these were surgical cases. The enteric fever patients made wonderful recoveries under the American cold-bath treatment. There were three deaths during the voyage.

**Dr. Schenk Coming.**—If there be any truth in a rumor widely prevalent, America is again to pay the penalty of her boast to be "a refuge for the oppressed of every nation," as Dr. Schenk, of "Determination of Sex" fame, is said to be about to betake himself to our shores. It will be remembered that he was compelled to resign his chair in the University of Vienna, on account of his famous brochure, some months ago.

## CORRESPONDENCE.

### OUR LONDON LETTER.

[From Our Special Correspondent.]

LONDON, April 21, 1900:

DIVISION OF PROFESSIONAL OPINION UPON MIDWIVES' BILL—THE ALLEGED ARISTOCRACY OF THE PROFESSION—REELECTION OF DR. CHURCH AS PRESIDENT OF THE COLLEGE OF PHYSICIANS—TELEGRAM TO THE PRINCE OF WALES—CESSPOOL UNDER RESTAURANTS IN LONDON—EXAMINATION OF MILK COWS IN LONDON—SATURDAY HOSPITAL FUND NOT SHRINKING—SIR WILLIAM PRIESTLY.

THE wide divergence which exists between the two great classes of English medical men, the consultants and the general practitioners, has seldom been more clearly and in some respects amusingly illustrated than in their attitude upon the proposed Midwifery Bill. The views of the former class are well typified in the editorial remarks of one of them in the *Practitioner*. These begin with the astonishing statement that many practitioners would be glad to turn over all their confinement cases to competent women, and that the majority would prefer to leave the cheaper class of midwifery in their hands! Than which a better illustration of utter and complete "detachedness" from the feelings and needs of the lowly family physician could hardly be imagined. Think of the possibility of holding family practice without attending labor cases, to say nothing of even the "cheaper class" of these, as indispensable sources of income.

In his further admonition to the mass of the profession that legislation of some sort is inevitable and that they will gain nothing and lose much by letting the impression get abroad that their opposition to it is merely a dog-in-the-manger fight to retain a paying monopoly, there is



probably more truth, although it is hardly to be expected that the struggling country doctor will relish hearing it from the serene heights of Brook Street or Cavendish Square.

On the other hand, the practitioners, both upon their editorial mouthpieces and by public meetings, are denouncing the bill as "calamitous," reproaching the General Medical Council and the College of Physicians and Surgeons for their lukewarmness in opposing and for even partially consenting to its passage. Their demand that the new licentiates should be termed "midwifery nurses" and permitted to practice only under the direction of a physician, does perhaps smack a little of selfishness and is certainly injudicious as insisting upon the unattainable, although it would redound to both the health and happiness of the community if it could win.

All this is simply typical of the friction which is continually cropping out between the two divisions, the officers and the privates, so to speak, of the medical army. The consultants have, not unnaturally, secured a heavy preponderance upon the great governing bodies and councils of the profession and as most of them have not been in general practice for years and some of them never in family practice at all, there is a continued cry going up from the rank and file of the profession for more direct representation upon these bodies and more sympathetic and intelligent action upon the questions of vital importance to the practitioner.

Even at the recent annual meeting of the Polyclinic, the question came up in the shape of a vigorous demand for larger representation upon the Council, whose twenty members it was alleged included only one actively and three nominally engaged in practice.

Dr. William Selby Church has been reelected president of the Royal College of Physicians in accordance with the unwritten law of that body in regard to second terms. The death-roll of the year was read by the President, and included such well-known names as Sir William Roberts, Sir Richard Thorne-Thorne, and the Reverend William Hicks (Bishop of Blomfontein). This, with the statement that the finances of the College are in a far from satisfactory state, gave rather a gloomy cast to the proceedings, but this was lightened somewhat toward the close by the ancient custom of carrying round a silver bowl filled with new silver coins (half-crowns) in small envelopes in payment of the attendance-fee of the members, and also by the, to transatlantic eyes, almost farcical announcement that a special telegram had been sent to the Prince of Wales congratulating him on his escape from assassination, His Royal Highness having recently been elected an Honorary Fellow of the College for some heaven-born reason.

The old and the established, no matter what its demerits, dies hard in England. It is reported upon apparently good authority that even today in London, the model sanitary city of the world in many respects, there are still houses

whose sewage is conducted into cesspools dug out of the soil directly beneath them. One or two prominent restaurants in the "City," the central business part of London, are said to be in this predicament and the effect of the emanations upon the health of their employees is said to be most noticeable. The effect upon the customers could be but slight in any case, but what of the food and cooking utensils kept over night in such places? The average cellar-restaurant or hotel kitchen is often a gruesome place at best without any sewage-fumes as an addition to its charms. The charge ought certainly to be rigorously investigated.

It is gratifying to note that the report of the Saturday Hospital Fund for 1899, just issued, shows, in spite of the enormous claims of the war, an increase of nearly \$5000 over the total for 1898, the entire sum being a little more than \$100,000. Still better, the abandonment of personal street-collecting for the Fund, which was coming to be regarded almost in the light of an annoyance, has not resulted in anything more than a most trifling diminution of the amount collected, hardly \$600 as between this year and the last one of the active collections.

The death of Sir William Priestly removes from the stage a figure whose prominence may be said to have been even greater outside of the profession than within its circle. Born of a family whose name stands high in the annals of science, a great-nephew of the famous discoverer of oxygen, of commanding presence and winning address, he had every natural endowment for success. And his success was largely of a personal rather than a purely scientific or literary character. The actual amount of his contributions to medical literature or progress was small in proportion to his prominence alike in practice, in Parliament, and in social circles. For years he had one of the largest and most fashionable consulting obstetrical practices in London, royalty itself being included in his clientele, which left him little leisure for writing or original research. He was, however, a prominent member of the staff of Kings College as consulting physician and professor of midwifery, and examiner in midwifery to the Royal College of Physicians and to the University of Cambridge and President of the Obstetrical Society, so that his activity in what might be termed the executive duties of the profession was great.

By a curious parallelism with Lord Lister, although born in England, he won his first reputation in Edinburgh where he was for three years in close association with Sir James G. Simpson, to whose tireless friendship and powerful influence much of his earlier success was due. It was largely upon his recommendation and vigorous championship that the young obstetrician was elected to the vacant chair of obstetrics in Kings College, shortly after he came to London, over the heads of two junior assistants and graduates of the College, who, by the sacred unwritten law of the London schools, considered

that the only choice of a candidate lay between them as Kings men. The skill with which Priestly soothed the irritation and outraged sense of propriety due to the "profanity" of his election, was a high tribute to his tact and gifts as a judge of human nature and manager of men, to which, indeed, his permanent success in practice was chiefly due, while his cleverness and fluency as a lecturer justified his appointment, so that he soon became personally popular with his colleagues, and on his resignation of the chair after only three or four years' occupancy, due in part to a severe attack of diphtheria and its sequelæ, he was unanimously elected consulting physician to the Hospital.

Although a Conservative all his life he was knighted upon the recommendation of Mr. Gladstone in 1893, and three years later was elected to Parliament as the representative of the Universities of St. Andrews and Edinburgh, one of the "blue ribbons" of scientific and literary fame in England. His work in the House was not of a prominent or highly public character, but his influence upon legislation, particularly that pertaining to the promotion of the public health was most useful and the profession was well represented by him. His death leaves a vacancy in Parliament which will probably be filled by another medical man, and Sir James Crichton Browne is prominently mentioned for the position.

#### TRANSACTIONS OF FOREIGN SOCIETIES.

##### French.

COMPULSORY NOTIFICATION OF PNEUMONIA AND BRONCHOPNEUMONIA—ACTINOMYCOSIS DURING THE PAST TWO YEARS—MOSQUITO-THEORY OF MALARIA NOT YET SETTLED—CHEYNE-STOKES RESPIRATION DURING SLEEP AS A SIGN OF COMMENCING CEREBRAL ENDARTERITIS.

At the Academy of Medicine, March 20th, GRANCHER urged that pneumonia and bronchopneumonia should be placed on the list of diseases of which notification is compulsory, because they are diseases which are always contagious whether occurring at the time of an epidemic or at other times. In case of these two diseases, and in case of tuberculosis, disinfection can render the greatest service, because the agent by which they are transmitted preserves its virulence for a long time and is relatively easily destroyed by boiling or by chemical means. With measles, for example, the reverse is true. It is only contagious during the period of invasion and ceases to be so when the eruption is well out. Hence disinfection is practically useless in cases of measles unless complicated by bronchopneumonia, while it would be of the greatest value in pneumonia, bronchopneumonia and tuberculosis.

VALLIN said that in the present state of science one is not justified in asking compulsory notification for pneumonia and bronchopneumo-

nia, unless an epidemic occurs or a form of these diseases which is markedly contagious—the virulence of the pneumococcus being exalted, as it were.

LEREBOULET objected to compulsory notification because one rarely sees instances in which disinfection would have prevented an attack of pneumonia, and also because many towns are without the means of proper disinfection.

After further discussion, April 3d, the Academy adopted the following resolution: "The Academy is of the opinion that the time has come to place *infectious* pneumonia and bronchopneumonia on the list of diseases of which notification is compulsory."

PONCET spoke at the meeting held March 27th of the cases of actinomycosis which were on record as occurring in France during the past two years. One should not make the mistake of relying upon the microscope for a diagnosis of this disease. The true diagnosis is a clinical one. The following symptoms are characteristic: A hybrid aspect, suggesting at once neoplastic and inflammatory lesions; slow and capricious growth, with cicatrization of old fistulæ in the immediate neighborhood of recent or extending lesions. Particularly on the face and neck, a diffuse induration, usually very painful, and muscular rigidity as soon as the superficial muscular planes are involved, and the absence of lymphatic enlargement, even although there are numerous sinuses and ulcers, are distinguishing characteristics. Of 26 cases reported, the disease occurred 21 times in the face and neck; twice in the cecal region, and once each at the umbilicus, anus, and in the pleural cavity. Inoculation invariably from an ear of wheat or the débris of cereals, almost always took place through the digestive tract. The progress of the disease was slow—3 months to 6 years—and often the parasites could not be found by microscopic examination until sought for many times. The termination of the disease was 15 times mentioned. Five patients died, 8 were well at the time of report, and 2 had suffered relapse. Surgical intervention did not appear indispensable. It should be confined to a simple incision, with scraping or cauterizing the sinuses. Iodide should be given internally. Eucalyptus has been recently highly praised, but Poncet said that he had not seen it accomplish any good result.

LAVERAN discussed the mosquito-theory of malaria, which he said was in harmony with many of the facts but not all of them, and to which there are some objections. For example, malaria is unknown in certain regions where mosquitoes flourish, while it occurs in some places where there are no mosquitoes. Observers are not agreed as to the method by which the mosquito transmits the parasite. If some experimenters have succeeded in producing malaria by the bite of a mosquito which had previously sucked blood from a malarial patient, a far greater number of such experiments have failed. The public should be impressed with the idea



that the larvæ develop in stagnant water and that any unnecessary stagnant water should be drained off, and the mosquitoes in the remainder should be killed by coal-oil or tar poured upon the surface of the water.

At the Medical Society of the Hospitals, March 16th, RABE spoke of the occurrence of Cheyne-Stokes' respiration during sleep in a patient whose kidneys acted normally during life and were shown to be sound at autopsy. The Cheyne-Stokes respiration was due to cerebral arteriosclerosis, combined with cardiac asthenia; and when it occurs under such circumstances it may safely be regarded as diagnostic of commencing arteriosclerosis.

## SOCIETY PROCEEDINGS.

### THE NEW YORK COUNTY MEDICAL SOCIETY.

*Stated Meeting, Held Monday, March 26, 1900.*

The President, George B. Fowler, M.D., in the Chair.

Dr. Clarence C. Rice read a paper on "Some of the Reasons Why the Surgical Treatment of Nasal Disease Has Been Placed upon a Conservative Basis." (See p. 641.)

**Therapeutic Cycles in Laryngology.**—In the discussion Dr. Beverley Robinson said that just as there are cycles in the therapeutics of most diseases, so there have been in the treatment of nasal affections. Twenty years ago Dr. Robinson insisted that the diathesis underlying certain manifestations in the nose was frequently much more important and needed treatment rather than the nasal disease itself. The constitutional condition of the patient, he urged, was the cause of the nasal symptoms and it was only by improving this that any permanent relief could be obtained. Although many changes have come in rhinology during the last twenty years, there seems no reason to change this opinion except, if possible, to emphasize it more strongly than ever. There is undoubtedly more danger in operations upon the nose than has been thought. Not only is there a certain amount of immediate danger, as reported deaths show, but there is a large risk of serious after-results from useless operations. Pathways for the entrance of germs are frequently provided by the mutilating effects of operations, and the physiological function of the nose as the gateway of the respiratory tract is often so interfered with that pulmonary affections become much more frequent than before. There is still a limited field for surgery in the nose, but it must be remembered that many of the operations done so thoughtlessly are of considerable moment and demand for their proper accomplishment a previous surgical training. The entrance of a number of men into laryngology and rhinology without previous

surgical training has undoubtedly hurt the surgical side of the specialty. The first principle of all medical treatment *non nocere* has only too often been flagrantly violated. Many a patient could have endured much better the nasal condition from which he was suffering than he can the results of operation that was supposed to relieve his symptoms. An occasional feeling of fulness in the nose is a good deal easier to bear than the scabs and constant dryness, with consequent discomfort, which will exist in the nose so persistently as the result of mutilating operations upon the nasal mucous membrane.

**Specialist and Family Physician.**—Dr. Robinson hopes to live long enough to see the time when the general practitioner will control the specialist and not only counsel his being called in consultation, but say how far he shall go in the application of his special therapeutic measures to the patient for whom he is called. As it is now, the practitioner among the better classes is little better than a soup-ladle, dishing out patients from his family practice for the various specialists. This is undignified and the time will come, and that before very long, when the family practitioner will resume all his old-time importance and then the mistakes that specialists continually make in carrying their fads too far will no longer be possible.

Dr. W. C. Phillips said that a little knowledge is a dangerous thing in any branch of medicine and that it has been particularly hurtful in rhinology. Specialists ready-made in a few weeks have considered that they were capable of judging of nasal conditions without reference to other parts of the body and mistakes have necessarily followed. Experienced workers in the nose have long since agreed that swollen turbinate bodies or a congested septum are not necessarily surgical conditions, but are often only symptoms of affections in other parts of the body. The local treatment of them will necessarily be unsuccessful in the end, although it may seem to give temporary relief. The only rational treatment is the therapeutics of the cause of the symptoms in the organs that are primarily affected. No specialist can hope to succeed unless he has been a general practitioner for a long time.

**Constitutional Treatment.**—Patients are often better freed from respiratory difficulties by a calomel purge than by any local measures, however well planned these may seem to be. Fortunately, patients are beginning to understand that symptoms in the nose do not always indicate direct local treatment. It was the custom to have patients come to the rhinologist with the remark that they wanted to have their noses bored out. This expression is no longer heard as frequently as it used to be, and the fact points to a very sensible change in the opinions of the laity with regard to nasal symptoms. The most important constitutional faults that give nasal symptoms are rheumatism, gout, and the uric acid diathesis. The most potent cause of nasal disturbance in general is digestive trouble.

Prompt relief of many a congestion and even of a certain amount of hypertrophy is frequently obtained by treatment of the digestive symptoms.

**Direct Causes of Nasal Symptoms.**—Dr. Rice's suggestion as to the influence of the use of alcohol and tobacco in excess as frequent causes of nasal symptoms is a most important and timely one. They are undoubtedly the cause of many conditions that have usually been attributed to quite other etiological factors. Cold in the head, that scapegoat for most acute nasal conditions, is usually not due to exposure to drafts. Patients who are the most careful with regard to exposure to cold acquire exacerbations of their nasal disturbance for very slight reasons. It is evident that other factors besides mere exposure to cold enter into the etiology of these nasal disturbances. The auxiliary causes usually belong to the realm of bacteriology, and it is here that we must look for the cause of acute rhinitis and pharyngitis which often leave their marks upon the nasal mucous membrane in the shape of chronic changes. Overwork and fatigue from overexertion frequently disturb the circulation and set up certain trophic nerve influences that become prominent causes in the production of nasal symptoms.

**Field for Operation.**—Dr. Robinson said that a number of young rhinologists would surely find in his nose indications for operating and some of them had even suggested it. This is not an unusual experience among rhinologists and it emphasizes the necessity for more conservatism in suggesting operations. There is a distinct field for operative surgery. Conservatism is not the only watchword. To treat nasal conditions without operative interference is surely to lose the great benefit that can be derived from surgery under appropriate circumstances. Nasal surgery requires, however, experience, skill, and training, just as does surgery in other parts of the body. If the speciality of the nasal surgeon is looked at in this way there is a great field for his labors.

**Diathesis.**—Dr. Quinlan said that the causes of nasal and laryngeal disease, if considered rationally, lead one far beyond what can be seen in the nasal speculum or the laryngeal mirror. In the talk about diathesis this evening the most important constitutional conditions that come under this head, namely, syphilis and tuberculosis, have been omitted. Constitutional conditions always influence and very often are the sole cause of nasal symptoms. It is not an unusual thing to have a parent bring back a child dissatisfied after the operation for adenoids. The apathetic expression, the mouth-breathing, the tendency to open mouth with its foolish look, something of the nasal speech, and other symptoms that it was promised would be cured by the operation still remain. The cause that led to the adenoids originally has not been eliminated and the symptoms that were made more marked by the presence of the pharyngeal tumors do not entirely disappear after removal of the latter.

The importance of water without and water within is becoming ever clearer in our modern life and must especially not be forgotten by the nasal specialist. In our dry superheated rooms conditions of the nasal mucous membrane develop that do not require special treatment, but demand more moisture in the air we breathe. Air and exercise are potent factors for the relief of nasal symptoms. A cold bath will often relieve rhinitis by causing a diversion of the blood supply into the cutaneous capillaries. It must be remembered that the turbinal tissue in the nose acts as the vestibule of the lungs to keep out impure and irritating air. Its function must not be hindered. If this great filter of the respiratory system is removed not only nasal symptoms will be much more prominent, but also the tendencies to pulmonary disease will be much increased. Conservatism must be the watchword of the operating laryngologist. It has taken a good many years to reach this standpoint. Now the lesson must not be lost. "Knowledge comes, but wisdom lingers."

**Excessive Smoking.**—Dr. Emil Meyer said that while excessive smoking undoubtedly does harm, the objection to the use of tobacco may become a fetish. Atrophic conditions of the nasal and pharyngeal mucous membranes occur also in females and in that class of females who do not smoke. In the same way alcohol is undoubtedly a serious factor in certain laryngeal conditions and yet the taking of moderate amounts may do no harm. There are extremes in the condemnation of alcohol and tobacco to which laryngologists should not go.

The electric cautery can never be condemned enough. The inventor of electric cauterization methods for the nose has undoubtedly a great deal to answer for. A distinguished specialist in rhinology said not long ago that the main part of his time was occupied in breaking down the synechiae of the nasal mucous membrane that had been left by electric cautery in the hands of the would-be rhinologist and the general practitioner. The galvanocautery certainly has a very limited place in the therapeutics of nasal diseases. The operative field for the specialist in rhinology must concern especially the treatment of the accessory sinuses of the nose. These the general practitioner can scarcely be expected to touch. He may put his patient into good general condition in order to be sure that the nasal symptoms will not disappear when this is done, and then, if there are symptoms that seem to implicate nasal sinuses, he should send his patient to a reliable specialist. For the specialist, under these circumstances, the best advice is Davy Crockett's maxim, "Be sure you're right, then go ahead."

**Surgical Technic.**—Much more consistent results in the field of nasal surgery will uniformly be obtained if careful precautions are taken to secure as far as possible an aseptic field for operation and the most thorough surgical care during and after the operation. It seems a good deal to



demand an assistant and a nurse for a simple adenoid operation. It looks like needless expense, but, after an experience of years with never a septic result with such accessories, Dr. Meyer is thoroughly convinced that the additional help is well worth the while. Dr. Goodwillie said that respiration is more important than food. If respiration is to be properly continued the mucous membrane must function normally. Mucous secretion must have a chance to get out, otherwise irritative conditions will surely develop. Dr. Goodwillie has, then, the very greatest respect for this important tissue. He saves all of it that is possible and hesitates as much to remove a bit of it as he would to remove any portion of visible tissue whose loss would be noticeable. Serious mistakes have been made in the past in removing this mucous membrane. Its removal is always followed by serious results. A good deal of bad surgery has been done in the nose during the development of modern rhinology. Adenoids must be removed, but only the hypertrophied granular tissue and not an indefinite amount of mucous membrane lying all around them. If other tissue is removed, harm will always be done. There have even been cases in which lasting injury has been done to the pillars of the fauces during an adenoid operation.

**Local and Constitutional Treatment.**—Dr. Rice in closing the discussion said that it must be remembered that it may be necessary to remove an occlusion of the nose, even if it should come from the liver or the lungs or from some digestive disturbance. This is especially true where the ear is interfered with. Constitutional treatment may be so slow in its action that important structures will be damaged before we are able to prevent by this means the development of lasting pathologic lesions in them. A great step in advance has certainly been made in rhinology in recent years inasmuch as we have done away with the use of nitrate of silver, zinc and copper solutions, which used to produce serious irritation of the nasal mucous membrane. When catarrhal conditions exist along the digestive tract the rhinologist can be of the greatest service to the general practitioner by relieving the catarrhal conditions of the upper part of the mucous tract. Disturbances of secretion in these parts react to produce reflex pathologic conditions in the stomach and other parts of the digestive tract.

**Requisites of the General Practitioner.**—Dr. August Caillé said that while the family practitioner used to be the all-important member of the medical profession he has now lost most of his prestige. The fact is that no one mind can contain all medicine and the all-round medical man is swamped by the amount of new material which is constantly accumulating on all sides in the realm of medicine. Even the specialist finds it hard to keep up in his own branch. If he knows but one language the difficulty is great enough; if he can read several then he realizes the fu-

tility of trying to absorb everything. The general practitioner has now become, in wealthy families at least, little more than the master of ceremonies in the direction of the health of the household. He diagnosticates in general the condition that exists and directs what specialist shall be applied to for treatment. The details of the treatment are carried out by a trained nurse. Medicine seems to many a field for the gaining of a good and easy livelihood. As a matter of fact, in recent years the profession has become overstocked. This has precisely the same effect as does an overstocked market. There is a drop in the prices to be paid and this will cause an inevitable diminution in the supply. There is not room enough for all who enter medicine. In the midst of this overstocking of the medical market there comes up this important question: Is there a place for the general practitioner or is his genus doomed to extinction? There are two reasons why the general practitioner, as such, will not disappear from the field of competition in medicine.

**Future of the General Practitioner.**—The two reasons why the general practitioner will live on is, first, that many people refuse to give him up. And, secondly, the public has come to realize during recent years the danger of immature specialism, and has taken to heart the important lesson that a large amount of the specialist's operative work is harmful or at least ill-advised. The family practitioner will save these mistakes by his good advice and so preserve his *clientele* from specialistic fads. The general practitioner may elect to develop for himself certain features of his work. He may, as it were, specialize, first, on physical diagnosis, second, on laboratory methods, third, on regional diagnosis, fourth, on dietetics, hygiene, hydrotherapy and physical methods of therapeutics, or fifth, on minor surgery. It is Dr. Caillé's opinion that he should not handle obstetrics. In the matter of physical diagnosis he should study especially the possibilities of information that may be gained from the careful examination of the various orifices of the body. He may not, perhaps, be expected to use successfully the ophthalmoscope or the cystoscope, but he certainly should be able to gain all ordinary information from the nose and throat and from the examination of the stomach-contents and from the use of specula. Patients cannot be expected to pay two fees for the diagnosis of conditions that involve no more special knowledge than these procedures. The diagnosis will certainly be expected of the general practitioner.

**Obstetrics and General Practice.**—There are two reasons why the general practitioner should not take obstetrical cases. First, they involve a considerable amount of night-work, and secondly, as general practice brings the practitioner in contact more or less with contagious diseases, this makes him a source of danger for the puerperal patient. The busy practitioner cannot do his patients justice if besides attempting day-work he stays up at night. His hysterical haste

is not paid for sufficiently and sins of omission inevitably ensue. The compensation that the practitioner would obtain for his obstetrical cases can be replaced by what he obtains for minor surgical practice. The simon pure medical practitioner has no place in future medicine. If a medical man objects to the use of the knife, his only hope is to drift into some bloodless specialty.

**Practical Considerations.**—A certain amount of laboratory work is very important for the general practitioner and will be even more so in the future. For this he no more needs a private laboratory than he needs a private livery-stable to keep his horse in. A great change will have to come over medical teaching in the very near future. An amount of valuable time during student-days is wasted in the study of valueless drugs that are still retained in the materia medica. The much more important therapeutic measures, mechano-, hydro-, and dieto-therapeutics are unfortunately neglected. These mechanical and physical methods, with a few drugs, must constitute the armamentarium of the practical physician. In order to keep up with the progress of medicine, the practitioner must do post-graduate work. This is more necessary for the country practitioner than for the medical man who lives in the city and who is more in touch with the progress of medicine. For post-graduate laboratory work, Europe is still ahead of us. Practical clinical post-graduate work can be done better here in this country. All medical men should begin their careers as general practitioners. Dr. Caillé does not hesitate to predict that the general practitioner of the future will be especially a diagnostician, a sanitarian and a minor surgeon.

**Few Successful Physicians.**—Dr. Walker said in discussion that he had been informed by the dean of a prominent medical college that only one out of every five medical men who graduate succeeds in making a living exclusively from his profession. There is no doubt that the profession is being overcrowded. Dr. Caillé's opinion that the practitioner of the future must devote his attention to minor surgery is a very suggestive thought. At least sixty per cent. of the ordinary young man's practice will come from this source.

Dr. Edebohls said it is important that the general practitioner should assure himself that his patient needs a specialist's care before he sends him to the specialist. Only the other day a puerperal woman was referred to him for curettage and he found absolutely nothing the matter with the sexual organs, but did find an acute pericarditis. It would have been extremely sad to have attempted operation in this case for death on the table would almost certainly have resulted from the anesthetic.

Dr. Knopf said that there is undoubtedly a great waste of time in the study of useless drugs. Much more time should be devoted to hygiene and diet than at present. The general practitioner should be able to detect incipient tuberculosis and

treat it. For this he may have to examine the members of predisposed families every six months. The procedure would certainly be thoroughly justified if by it we were able to keep in abeyance the great white plague of the north.

**NEW YORK ACADEMY OF MEDICINE.—SECTION ON LARYNGOLOGY AND RHINOLOGY.**

*Stated Meeting, Held Wednesday, March 28, 1900.*

Wendell C. Phillips, M.D., Chairman.

Dr. Coakley presented an improved transillumination instrument. The instruments at present in use for this purpose are very hard to sterilize thoroughly. Dr. Coakley provides a glass tube that fits over the electric lamp and goes somewhat beyond it. It is this tube alone that comes in contact with the patient's mouth. It can easily be removed and thoroughly sterilized by boiling. This glass covering serves besides the very useful purpose of keeping the transilluminator cool enough to allow of its presence in the mouth for a considerable time. Glass itself is a poor conductor of heat and besides there is a non-conducting layer of air between the lamp and the outer glass tube, which further prevents any disagreeable heating of the outside of the instrument.

Dr. Levin presented a case of atrophic rhinitis at the age of twelve years. The patient has now been under his observation for some four years. The condition was well marked at the beginning of that time and has progressed but slightly. By careful cleansing the patient is kept reasonably comfortable, although otherwise the affection seems to yield very little to treatment.

The subject of the evening, the discussion of atrophic chronic rhinitis, was then taken up.

**Etiology of Atrophic Rhinitis.**—Dr. Frank H. Bosworth said that the opinions on this subject expressed in his paper at the Congress in London, some twenty years ago, remain still substantially unchanged. He there presented some specimens from the mucous membrane of cases of atrophic rhinitis, which had been obtained by the snare—a perfectly unjustifiable procedure, except for the scientific value of the observations made possible by it. At that time he expressed the opinion that chronic atrophic rhinitis is a development from purulent rhinitis of long duration. Before that the general opinion had been that atrophic rhinitis develops somewhat as does atrophic cirrhosis of the liver. It was considered that hypertrophic rhinitis is the primary stage. Only one case of such a progression has ever been recorded. If that is to be accepted it is unique in medical literature. Inflammatory conditions in the mucous membrane do not, as a rule, lead to the production of connective tissue, but only to an increase of secretion. In children the process is confined to the epithelial layer and



proliferation of the epithelial cells takes place so that the original mucous secretion becomes cloudy and almost purulent in character. The process then extends into the simple and compound follicles of the mucous membrane with a like involvement of their epithelial cells. A deposit of connective tissue then takes place around the follicles. Like all connective tissue this has a tendency after a time to contraction. After a year or two, sometimes three or four, of excessive secretion the secretory fluids become thick and inspissated. They form thick crusts and their contraction interferes by pressure with the blood-supply. Between the contractile connective tissue within the mucous membrane and the crusts on its surface the blood-supply to the turbinated bodies is very much interfered with. The mother of bone, the periosteum in this region suffers and the result is a failure of the turbinated body to develop properly.

**Origin of Symptoms.**—Theories almost without end have been very ingeniously constructed to explain the various symptoms of the disease. A special form of secretion has been suggested as the cause of the crusts, or a special form of bacillus that causes the mucous material to become inspissated. A number of theories have been advanced to explain the disagreeable odor also. To any one who uses common sense, however, this does not seem very hard to explain. Animal matter, that is, albuminous material of very unstable chemical equilibrium, is retained for twenty-four to forty-eight hours in the nose. It would be surprising, then, if it did not decompose and smell. Chronic atrophic rhinitis usually commences in childhood at five or six or seven. After five to six years of progress, crusts are formed and then the odor begins to be the most notable symptom. Amelioration of all the symptoms very frequently takes place at the age of forty, or shortly thereafter. Dr. Bosworth has seen but one case of fully-developed atrophic rhinitis chronica in a girl of twenty-one that was completely cured. The rhinologist is in a much better position, therapeutically considered, at present with regard to the disease, than he was some years ago. All of the symptoms can now be so controlled that the patient has comparatively little discomfort, while the annoying smell, so offensive to friends, can be so overcome as to be unnoticeable.

**Recent Contributions to Etiology and Pathology.**—Dr. Jonathan Wright discussed some of the recent theories brought forward by German authorities as to the etiology of chronic atrophic rhinitis. The subject has been approached from the standpoint of ethnology and craniology. It has been pointed out that it is especially the flat type of skull that is liable to be affected by this atrophic condition of the turbinate bones. The form of skull has a definite relation to the form of the nasal passages and this latter to the development of atrophic conditions. In Switzerland it has been noted that in 97 per cent. of patients ozena occurred in individuals who had

more than the average width of face. In a word, fetid rhinitis occurs only in the broad-faced. It has also been noted that there is a congenital metaplasia of the epithelial cells of the nasal mucous membranes. Instead of cylindrical epithelium, which is normal to this part, squamous epithelium occurs as the result of congenital influences. Individuals so affected later develop atrophic rhinitis. This tendency to squamous epithelium within the nose occurs especially in the broad-faced type of skull, in which the more open nostrils and consequent exposure of the epithelium to the air lead to its taking on more the character of the neighboring skin surface. These observations on skull types and their influence on the development of atrophic rhinitis have been made so far only in Switzerland. As is well known that the brachycephalic type of skull prevails very generally in Switzerland. It would not be surprising, then, to find that a large proportion of people afflicted with any ailment there would be of the broad-faced type. It is doubtful if a corresponding series of observations made, for instance, in the Iberian Peninsula where the dolichocephalic type of skull prevails, might not give directly opposite result. Meantime this theory of the etiological connection between the type of skull and the development of atrophic rhinitis adds another and a very interesting phase to the discussion of the etiology of the affection. We have heard it said that atrophic rhinitis chronica develops from hypertrophic rhinitis, or from purulent rhinitis; that it occurs in people with high palates, or, according to others, in people with especially low palates. Bacteriology has put in her claim to explain the origin of the disease, and the pseudodiphtheria bacillus as an etiological factor had for a long time quite a vogue. Of late it has been claimed that the disease is originally a neuropathy, that is, an atrophic neurosis. Evidently it is not yet possible to decide what the etiology of the disease is. It is probable that most of the factors mentioned have some influence, while no one of them is the exclusive cause. It must be borne in mind in discussing the etiology of chronic atrophic rhinitis that the affection preponderates in women. At least 70 per cent. of the patients, according to a large number of statistics, are of this sex. It has been pointed out that women have not only actually, but relatively, a smaller nose than men. This has been taken to indicate that it is especially smallness of the nose which predisposes to the development of the affection. Hereditary syphilis has been claimed to play an important part in the causation of the disease. Fournier has now pointed out that, as the result of hereditary syphilis, not only do various deformities of the nose occur, but patients are apt to be born with a relatively smaller nose than is normal, though the organ may be perfectly regular. This question, however, needs further observation before any decision as to the value of this factor in the etiology of the disease can be made. One thing is certain, the bacteriological factors that a

few years ago were considered so prominent in the etiology of chronic atrophic rhinitis are now, in the words of a distinguished statesman, sinking into "innocuous desuetude."

Dr. Clarence C. Rice said that dry mucous membranes may exist for long periods and yet not be due to chronic atrophic rhinitis. All dryness of the mucous membranes of the nose used to be diagnosed as atrophic rhinitis. We now know that an absence of secretion may exist for years, while normal mucous membrane remains and no true atrophy develops. This absence of secretion is often due to general malnutrition. It is especially seen in dispensary practice, because poor patients are liable to be living under conditions of diet, overwork, absence of good air and sanitation that make profound malnutrition very frequent. Another form of dry rhinitis occurs without atrophy in fat, phlegmatic people, especially those who use alcohol to excess. It is very constantly found in mouth-breathers. This dry rhinitic condition may be cured by discontinuing the alcohol and reducing the weight of the patient.

**Differential Diagnosis.**—Functional collapse of the mucous membrane, with absence of secretion and an anemic appearance, occurs especially in young adults of the poorer class, whose general condition shows that they are not in the best of health. True atrophic rhinitis occurs especially in children of any class, rich or poor, and the patients are frequently in good general health. In functional collapse the typically-wide nostrils of true atrophic rhinitis do not exist. In atrophic rhinitis there is destruction of the turbinate bodies and the mucous membrane covering them looks thin and granular, and usually has crusts on it. The extremely fetid odor is a very characteristic symptom. In simple dry rhinitis the mucous membrane has an anemic look, but does not seem degenerate and, while the breath may be unpleasant from general disturbance of the digestive tract, it is not as offensive as in true ozena. The middle turbinate body is very often enlarged in atrophic rhinitis. This enlargement does not occur in functional collapse. The milder condition does not usually end in atrophy. No heroic treatment is needed for functional collapse of the nasal mucous membrane. As soon as the general health can be improved relief will be experienced from the symptoms noticed and the appearance of the nasal mucous membrane will alter for the better.

**Hygienic and General Treatment.**—Dr. Delavan read for Dr. Thomas R. French of Brooklyn a paper on this subject. Under the term hygiene Dr. French does not include the precautions necessary to avoid nasal affections due to occupation. For these very little can be done except a change of occupation. The main lesson to be learned in the hygiene of the nose is how to cleanse and how not to cleanse the nasal mucous membrane in chronic atrophic rhinitis. Rhinologists differ widely as to the etiology of the disease, but they are agreed that the indications are

to cleanse the nostrils locally, to stimulate the mucous membrane and to destroy the odor. The modern syringe is apt to be very unclean, and while the best-intentioned efforts are being made for the cleansing of the nostrils, the condition of the syringe may render the attempt nugatory. Some time ago, at Dr. French's suggestion, Dr. Van Cott drew up into a nasal syringe, supposed to be ordinarily clean, some sterile bouillon and allowed it to remain for a few minutes. The bouillon was then allowed to stand for a time and some of it injected into the peritoneal cavity of a guinea-pig. The animal died in eighteen hours from septicemia. In the peritoneal fluid a short bacillus and a micrococcus were found. Syringes that are as liable to contamination as this should not be used. Dr. French has recently had made a syringe the plunger of which is made of asbestos. This can be thoroughly sterilized by holding it over an alcohol lamp for a few minutes. This makes the syringe much less liable to carry infective material than with the old form of plunger, which practically cannot be sterilized. Dr. French likes the spray as least as well as the douche under all circumstances, and he considers that there is less danger to the ear from the use of the former. All atomizers should be boiled before use even when they are presumably new. Frequently atomizers are used once by a patient and then returned to a drug store to be exchanged. There is no guarantee, then, that because the atomizer is direct from the druggist's it may not be infected with micro-organisms. Strong antiseptics should not be used in the nose, and alkaline solutions are better borne than neutral or acid ones. For the dry feeling which causes so much discomfort, some oily solution should be used. This is only palliative in its effects and should be used intermittently. Its constant employment will lead to the nasal mucous membrane giving up entirely its function and will eventually make the condition worse.

The use of antitoxin for chronic atrophic rhinitis had many strong advocates not long ago, but they are constantly dropping out. Where tuberculosis exists, care should be taken to treat the patient for this condition and improve the general health as much as possible. Anemia or any dyscrasia should be appropriately treated. A change of climate commonly does good, notwithstanding the fact that a moist atmosphere is usually the most comfortable for the patient, the seashore is not always the best place for him. Quinine, iron and strychnine should be used freely where the general health is impaired. Inunction with oil often seems to be an excellent method of improving the general health where there has been considerable loss of weight. With regard to the underclothing, the use of linen mesh seems advisable. This underwear prevents to a great extent the tendency to take cold, often so noticeable in these cases. There still remain many defects in our treatment of chronic atrophic rhinitis, but we can control the fetid secretions almost entirely now and so make pa-



tients much more comfortable than they used to be.

**Electrical and Mechanical Treatment.**—Dr. Bryson Delavan said that mechanical treatment consists in the use of tampons, plugs, bougies and the curette. Gottstein's suggestion of the use of non-absorbent cotton was undoubtedly a step in advance in the treatment of chronic atrophic rhinitis. Certain drugs may be employed with advantage on the tampon and the medicated material gives better satisfaction than the plain. The use of the curette is justified where areas of hypertrophy of the mucous membrane exist besides the atrophic condition. The hypertrophic patches are apt to occur especially at the upper part of the septum. The galvanocautery may be used for the same purpose as the curette; for any other purpose it is sure to do harm, not good.

**Preventive Treatment.**—There is no doubt that chronic atrophic rhinitis is less common than it used to be. The reason for this appears to be that nasal disease is now treated more effectually and patients apply for treatment for nasal symptoms earlier than they used to. Chronic atrophic rhinitis is apt to follow the exanthemata. Especially is this so where obstruction of the nose existed before the occurrence of the eruptive fever. The nasal passages should be very carefully watched, then, during the course of the exanthemata and prompt relief afforded to any nasal obstruction that may occur. This method limits the development of chronic atrophic rhinitis and may prevent it entirely in cases where it would otherwise occur.

Dr. Charles H. Knight said that chronic atrophic rhinitis is one of the diseases for which a great many remedies have succeeded each other year after year. Its treatment is not hopeless in all cases. The affection does not depend only on local conditions, but is often due to a vicious constitutional state, which can be improved by drugs. Where syphilis, or struma, or frank tuberculosis, or the rheumatic or gouty diathesis, or alcoholic bad habits exist, these must be brought under the influence of treatment as effectively as possible and the result will always be an improvement in the nasal condition at least as far as symptoms are concerned. The most distressing symptom is the *ozena*. This symptom, it must be remembered, may also be produced by syphilitic processes, or by obstruction from deformity or from a foreign body. All of these are very tractable conditions if treatment be prompt. The diagnosis of chronic atrophic rhinitis should not be made, therefore, from the smell alone. A very careful examination should be made to decide that no other cause is at work. The smell in chronic atrophic rhinitis is not in proportion to the amount of secretion, nor to its character. The tissues in some cases seem to have an inherent odoriferous quality, which it is not easy to explain. In treating the *ozena*, the remedies employed should be already in solution. The use of dry powder in the nose requires the presence of enough secretion to dissolve it, before it can act

effectively. This is putting extra labor on tissues that are already lowered in their physiologic function of producing secretion. Crusts that form should be removed with cotton on a probe after a preliminary softening by means of an alkali wash, or atomized oil.

The most useful drug in chronic atrophic rhinitis is menthol. It improves the quantity of the secretion, lessens the tendency to crusting and decreases the smell. A five-per-cent. solution will usually be borne very well at first and may be increased later on. The best fluid application is albolene. It should be used in the form of a spray. When used this way it is not necessary to warm the fluid beforehand. The process of atomization makes the solution cool, no matter how warm it may be originally. Formaldehyde is theoretically an excellent drug to use in chronic atrophic rhinitis. It should act as an antiseptic and as a deodorant. Employed in solutions of 1-5000 it has given good satisfaction. Even thus diluted, however, it sometimes produces irritation. This should be guarded against. It may be employed twice a day after preliminary cleansing with salt solution. Boroformalin is a very good form of the drug to use. Borolyptol has given very good satisfaction in recent years. The *ozena* is distinctly modified and in certain cases seems to have been practically completely overcome. Ichthyol has given very good results in chronic atrophic rhinitis. It is used in solutions of two to five per cent., the diluent usually being petrolatum. Its unpleasant odor, however, makes it objectionable. Very recently buminol has been recommended, because of its extraordinary antiseptic powers and its absolutely unirritating properties. It is besides an excellent deodorizer. All in all it is the most promising drug at present being used for this bothersome affection.

No operation should be done for the removal of tissue in chronic atrophic rhinitis unless obstruction exists. Where cirrhosis of the submucous tissue has already set in, the ultimate prognosis of the case is not good. At times, however, the development of this sclerotic condition may be prevented.

**Some Bacteriology of Atrophic Rhinitis.**—In the discussion Dr. Van Sant of Philadelphia said that he had examined 100 cases of chronic atrophic rhinitis in order to decide what bacteria were present. In all of them bacteria were found very plentiful. In 25 of them the pseudodiphtheria bacillus was present. In the first case examined bacteriologically the Philadelphia Board of Health reported that the patient had diphtheria and must be isolated, although he was an ordinary business man going about his avocation every day. There are signs in the general condition of patients suffering from chronic atrophic rhinitis which point to the fact that they are suffering from autointoxication. These toxins are absorbed from septic foci in the nose. Their presence in the circulation causes the sense of lassitude and neurasthenic unrest of which

patients suffering from atrophic rhinitis so often complain. Improvement comes with the use of iron, fresh air, and general hygienic conditions.

Dr. Coyle said that the most useful drug in his practice is hydrozone. After that borolyptol. The best method of treatment seemed to be the insertion of plugs of gauze which are put in with a plug-placer and allowed to remain for twenty-four to thirty-six hours. The tampons themselves do more than any of the remedies that may be employed with them.

Dr. Freudenthal said that the main feature of chronic atrophic rhinitis is the dryness. The main reason for the development of chronic atrophic rhinitis so commonly in this country is the intensely dry air of our houses. In order that the nasal mucous membrane may be comfortable the relative humidity should be at least 60 per cent. As a matter of fact the relative humidity in the living-rooms of our modern houses is never more than 40 per cent., is often less than 30 per cent., and may in steam-heated houses be as low as 15 per cent. When dry air is breathed the mucous membrane keeps giving off moisture constantly. This increase of function finally leads to atrophy, although in the middle turbinate body which does most of the work hypertrophy is usually noticed. Vibratory massage has given the best results in Dr. Freudenthal's hands.

Dr. Douglas said that there are cycles of improvement in chronic atrophic rhinitis almost as in phthisis. It is very hard to decide, then, with assurance what drugs locally or internally used give good results. Two drugs are certainly always of benefit. Ichthyol which may be used in a fifty per-cent. solution, or rubbed in pure, after the employment of a cleansing douche. Ichthyol applications produce a serous exudate and they lead to the absorption of the leucocytic infiltrate. Very recently Dr. Douglas has seen carbon dioxide used under Dr. Achilles Rose's direction with extremely satisfactory results. For atrophic cases with extremely bad odor nothing is more effective. In dry cases with marked atrophy, it seems to do great good in making the erectile tissue more succulent.

Dr. Miles thinks that the etiology of atrophic rhinitis is due to two factors. First, there is imperfect development of the nasal mucous membrane as the result of congenital defect. This mucous membrane becomes a *locos minoris resistentiae*. Bacilli attack this mucous membrane in youth and so bring on the atrophic condition. The treatment of the future will undoubtedly be instituted during the preliminary stage, that is some time from two to eight years of age. Ichthyol is the best remedy. It may be used in a twenty-five-per-cent. solution with vaseline or pure on a probe. Iodine internally often does distinct good in these cases, and its use should not be neglected.

Dr. Quinlan thinks that chronic atrophic rhinitis is becoming rarer because more care is taken of the nasal tissues in early life than used to be

the custom. Children are brought for treatment as soon as the first symptoms of nasal trouble manifest themselves and so are saved the development of the incurable chronic condition. City children have not enough air and sunshine and are asked to apply themselves too much to their books. The constitutional conditions are certainly important in the development of most nasal conditions and especially of atrophic rhinitis.

Dr. Meyer thinks that after the exanthematic diseases atrophic rhinitis is especially liable to develop. It has been noted that adenoids disappear during an attack of one of the exanthemata. The atrophied condition of the glands of the nasal mucous membrane may be brought about in the same way. The most careful precautions should then be taken to prevent the development of chronic nasal conditions after these fevers.

#### WESTERN OPHTHALMOLOGIC AND OTOLARYNGOLOGIC ASSOCIATION.

*Held at St. Louis, April 5, 6, and 7, 1900.*

The President, W. Scheppergrell, M.D., in the Chair.

The President opened the meeting with a paper on "The Rise of Specialism," in which he disproved the oft-repeated charge that specialisms in medicine are modern innovations. He cited historical data dating several centuries before Christ in which distinct references were made to specialists of the eye, stomach and the head. The essayist commended specialists in medicine, as they promote more detailed study and thereby lead to higher medical attainments.

J. W. Bullard, M.D., of Pawnee City, Neb., read a paper on "Two Classes of Eye Cases That Give a Great Deal of Trouble." Chief among them were those in which irritation and dryness of the conjunctiva persisted in spite of every attempt at refraction which had been made.

Edwin Pynchon, M.D., of Chicago, read a paper, entitled "Slight Irregularities of the Nasal Septum." The author advocated the removal or correction of slight irregularities of the septum when there were disturbances of the nasal functions on account of their presence. If later and larger developments justified their removal, the author thought their early removal was justified on the grounds of "A stitch in time saves nine."

C. R. Holmes, M.D., of Cincinnati, read a paper on "Foreign Bodies of the Orbit, with Report of Cases." About seventy cases were compiled from the literature by the author and three additional ones were reported by him. The most interesting and unique case was one reported by the author. It consisted of a knife-blade about 1-1½ inches long which had been in the orbit thirty-two years without causing much inconvenience. It was imbedded in a fibrous capsule and was but slightly rusted.

M. A. Goldstein, of St. Louis, reported two



cases, viz.: (a) Primary Tuberculosis of the Ear; (b) Primary Tuberculosis of the Larynx.

(a) The case had been operated on some years previously and had a recurrence some months ago, at which time Dr. Goldstein did the Schwartz operation. Bad symptoms developed a few weeks ago and he did the radical operation, since which time the patient has been doing well. (b) The second case was one of probably primary tuberculosis of the larynx, which came under the observation of the author about one year ago. At that time he was in a very serious condition; death seemed but a matter of a few weeks or months. The patient was growing greatly emaciated, and in response to the treatment administered had gained a fair degree of health, being able to attend to business. The diagnosis in the case is somewhat doubtful, but the author, having excluded lues and malignant growth, has made the diagnosis of primary laryngeal tuberculosis. Tubercle bacilli are absent and the tissue has not been examined microscopically.

Dr. Wm. L. Ballenger, of Chicago, read a paper on "The Physiologic Tests of the Organ of Hearing as Aids in the Differential Diagnosis of Lesions of the Ear." The author advocated the physiologic tests of the ear, including the range of hearing, as tested with the tuning-fork, Galton whistle, the Webber experiment, the Rinne experiment, the Schwaback and Bing tests, as important aids in the differential diagnosis of the lesions of the ear. They are of special importance in determining the location of the lesion. He suggested that in a general way the deeper the structure involved, the more pronounced the disturbance of hearing and the less probability of a cure. The tests were therefore recommended more for the purpose of aiding the surgeon in giving a correct diagnosis than for the purpose of aiding him in the treatment, which is often unsuccessful. Six cases were cited illustrating lesions of different kinds in the middle ear and labyrinth, in which the tests were used for the purpose of differentiating them. He recommended that the tests be made in all cases of ear disease in which there was marked deafness and tinnitus, both before and after the inflation of the tympanum. If this point is neglected the diagnosis may not be properly made. While the physiologic tests are not absolute guides to a correct diagnosis, they are, together with all other means of diagnosis, the most correct at the command of the aural surgeon and therefore should be invariably used.

O. J. Stein, M.D., of Chicago, read a paper entitled, "Symmetrical Osteoma of the Nose; Report of a Case." The author reported a very rare case of symmetrical or double osteoma of the nose, occluding the nasal chambers and extending to either side for a considerable distance, whereby the patient was given the typical frog-face appearance. Osteoma upon one side is rather common. This case was presented on account of its unique type and was reported with a number

of other cases collected from the literature. No attempt was made to correct the deformity, as the patient is well advanced with tuberculosis, several other members of the family having died with the same disease.

J. O. Stillson, M.D., of Indianapolis, read a paper on "Removal of the Middle Turbinate for the Cure of Some Forms of Inveterate Eye Disease." The author read a very interesting paper upon this subject in which he reported his observations as to the relationship of nasal and eye diseases and the results he had obtained in allaying eye symptoms by the treatment of nasal conditions, more especially the removal of the turbinate.

Dr. Goldstein, as Chairman of the Local Committee of Arrangements, arranged for a museum of pathologic and anatomic specimens which, while not large, was extremely interesting and marks a new departure in this society.

Dr. M. A. Goldstein of St. Louis was elected president for the ensuing year.

## REVIEWS.

*The Treatment of Diseases of the Nervous System. A Manual for Practitioners.* By JOSEPH COLLINS, M.D., Professor of Nervous and Mental Diseases in the New York Post-Graduate Medical School; Visiting Physician to the New York City Hospital. Illustrated by Twenty-three Engravings. Cloth. Pp. 602. New York: William Wood and Company, 1900.

AMONG the various books on nervous diseases this work stands out as promising to be one of the most useful to the general profession. The aim of the author is to present in detail to the general practitioner the best and latest treatment of diseases of the nervous system. This he has succeeded in doing, symptoms and etiology being secondary considerations, although etiology is presented fully but concisely, because of its relation to the conscientious treatment of the diseases.

The book is divided into three parts. Part I. treats of the causes and origination of diseases of the nervous system in general and of the prevention of these diseases. The chapter on general etiology is well worth reading and should be read by every general practitioner. It presents the subject in a comprehensive form, each factor being considered in detail. As to the rôle of infection, the author thinks that such diseases as beriberi, Landry's paralysis, and anterior poliomyelitis, which are thought to be due to some specific organisms, will be found, when these organisms are isolated, to be due in reality to bacteria which cause more common diseases in other parts of the body. In other words, he does not think that any disease of the nervous system is dependent on an

organism that causes a specifically nervous disease.

Diseases of the nervous system due to syphilis are divided into syphilitic and parasyphilitic. The genuine syphilitic diseases are subdivided into: (1) Syphilitic disease of the blood-vessels; (2) syphilitic disease of the parenchyma of the central nervous system; (3) syphilitic disease of the coverings of the central nervous system, particularly the meninges; (4) syphilitic new formations of sufficient size to deserve the name of tumor; and (5) syphilitic neuritis, a condition that is rare, but whose actual occurrence would seem to be fairly well substantiated.

The parasyphilitic diseases, which are always degenerative *ab initio*, are: (1) Tabes dorsalis; (2) general paresis; and (3) some neuroses, including syphilitic neurasthenia, epilepsy, neuralgia, and possibly hysteria. The author believes that antisiphilitic treatment has little if any influence to prevent the occurrence of parasyphilitic diseases of the nervous system. In the chapter on prevention, a number of pages are devoted with advantage to the education and bringing up of the neuropathic child.

Part II. treats of the general application of remedial measures in the treatment of nervous disease. There are seven chapters, one each on drugs, hydrotherapy, electrotherapy, massage, exercise, rest and occupation, diet, and psychotherapy. In the chapter on drugs, the use of tetanus antitoxin and the thyroid gland, with the methods of their administration, is considered. The abuse of opium and the bromides is discussed, and a number of drugs useful in diseases of the nervous system are considered in detail, with points as to the best preparation, dosage, and manner of administration of each. The value of hydrotherapy, electrotherapy, and massage is discussed in the following three chapters, and the various forms, manner of application, length of each treatment, the diseases benefited, and the results to be expected from each form of therapy are considered. The chapters on diet and psychotherapy contain many useful suggestions.

In Part III., which considers the treatment of individual diseases, the author has made no attempt at classification, but has taken the subjects up in the following order: Diseases of the brain, of the spinal cord, of the peripheral nerves, of the sympathetic nervous system, the functional nervous diseases, and, finally, the most common symptomatic manifestations, such as headache, delirium, convulsions, hemiplegia, and insomnia.

The etiology of the various diseases is given rather fully, the symptoms are portrayed in as few lines as possible, while the treatment, in accordance with the purport of the book, is considered fully and in detail. The author has given proportionately much more space to the discussion of headache, neurasthenia, vertigo, and other functional and symptomatic states than to most of the organic diseases, for the reason that the

former occur more frequently and cause more suffering. In considering the treatment of tabes, Fraenkel's method of re-education of the ataxic extremities is described and illustrated by a few engravings.

On the whole, this work of Collins is exceedingly good and will prove of interest and value to every general practitioner as well as to specialists in this branch of medicine.

The volume is illustrated by twenty-three engravings. It is disappointing that an otherwise admirable book should be printed on such a poor quality of paper as is used in this.

*A System of Medicine by Many Writers.* Edited by THOMAS CLIFFORD ALBUTT, M.D., M.A., etc., Regius Professor in the University of Cambridge; Fellow of Gonville and Caius College; Hon. Fellow Royal College of Physicians of Ireland. Volume IX. New York: The Macmillan Company.

THE present volume contains quite an assortment of topics. About 170 pages are devoted to a number of the neuroses. Craft Palsies, Torticollis, Tics, Paralysis Agitans, Migraine, Hysteria, Latah, Catalepsy and Neurasthenia are included here under this title. These are all excellent treatises, that on Neurasthenia, by the editor, being especially noteworthy. It is also worthy of note that migraine is considered as a toxic disease affecting the sympathetic nervous system. The section on Mental Diseases occupies over 250 pages, and, while not a complete treatise on insanity, it contains a number of suggestive articles by well-known writers. Dull, Delicate and Nervous Children by Frances Warner, and Vice, Crime and Insanity, by Dr. Mercier are valuable and forceful presentations of subjects now prominent in discussion. The chapter on Epilepsy and Insanity is also to be commended. The treatment of the main types of insanity, to which a special chapter is devoted, offers much that is new and suggestive.

The remainder of the book is concerned with Diseases of the Skin, these occupying 500 pages. The discussion of the various skin lesions is excellent, but the restrictions in the matter of illustrations render this portion of less value to the practitioner than many modern works on dermatology. The present volume is well up to the excellent standard of the others.

*Twentieth Century Practice. An International Encyclopedia of Modern Medical Practice.* By Leading Authorities of Europe and America. Edited by THOMAS L. STEDMAN, M.D., New York City. Volume XVIII. "Syphilis and Leprosy." New York: William Wood and Company., 1899.

THE eighteenth volume of this well-known system of medicine opens with a comprehensive description of acquired syphilis by Professor Lang of Vienna. "We have every reason to look for a living organism in the syphilitic contagium;



but as we have not yet found it, we are unable to give a precise definition of syphilis. We must at present be satisfied to characterize the disease by enumerating the effects produced by the contagium." The author gives a good account of the variety in clinical appearance and distribution of the initial lesion. The account of syphilis of the nervous system is thorough, as is that of the osseous system. The description of joint syphilis is very meager. In the account of the blood changes in syphilis we are surprised to find a statement as manifestly incorrect as this: "Ehrlich discovered that the presence of cells with neutrophile eta-nuclei is characteristic of myelogenous leucemia." The author evidently is not well versed in modern blood pathology. We are glad to observe that due credit is given to the work of American syphilologists. The author is a firm believer in electric cataphoresis and extols the value of the electric sublimate baths.

Only twenty-eight pages are devoted to the subject of inherited syphilis, by Jonathan Hutchinson of London. More space should have been given to this important subject. From a recognized authority, as is Dr. Hutchinson, we expected much more than the meager account he has written.

Dr. Prince A. Morrow of New York contributes a long paper on "Leprosy" and gives a good description of the various stages and manifestations of the disease. The illustrations are excellent. The account of the geographical distribution of the disease and the methods of dealing with it in ancient and modern times is admirable and shows that the writer has a thorough knowledge of the literature of the subject.

*Diseases of Women.* A Treatise on Principles and Practice of Gynecology for Students and Practitioners. By E. C. DUDLEY, A.M., M.D., Professor of Gynecology in the Northwestern University Medical School, Chicago. Second Edition, Revised and Enlarged. 8vo., 717 pages. Illustrated. Philadelphia and New York: Lea Brothers & Co.

THIS second edition is even more attractive than the first and has some additional chapters, although the volume is preserved in its original convenient form. The plan of dividing the subject on the basis of pathology, which is a characteristic feature of the book, has been retained. The functional disorders of menstruation and sterility, although still recognized as symptoms only, have been skeletonized and presented in four new chapters. This addition introduces also thirty-one new engravings and six new full-page plates. The abundance of colored plates and pictures form an especially attractive and desirable feature.

There are one or two points in which we had looked for improvement. One was in reference to the teachings regarding the function of the perineum. We are surprised to find the author still declaring that the perineum is a support to the uterus. The abdominal muscles support the

head, but we do not often speak of them in that connection.

In the chapter on perineorrhaphy the author has confined himself to one procedure, namely, the Emmet operation, and, although he has made this comparatively plain, it still remains a complicated procedure and difficult for the majority of the profession to understand. There are other and simpler operations that give quite as good, if not better, results. In a work for students it would seem desirable that they should at least have the opportunity of understanding and adopting them. Each subject is concisely and definitely treated, and it is evident that the author relies upon his personal experience to justify his teaching. No recent book presents the practical side of gynecology in so complete, attractive and available a form.

*A Pocket Text-Book of Diseases of Women,* by MONTGOMERY A. CROCKETT, A.B., M.D., Adjunct Professor of Obstetrics and Clinical Gynecology, Medical Department of the University of Buffalo, N. Y. Lea Brothers & Co., Philadelphia and New York. Price, \$1.50.

THIS new volume of the series is in no way inferior to the volumes which have preceded it. The author has not forgotten that clearness and conciseness are, for the student, of the foremost importance; yet the completeness of the text will make it no less welcome to the practitioner. The first three chapters are devoted to a general discourse on diagnosis, local treatment and gynecological operations, which in every way conform to the latest concepts of the science. In the discussion of the separate diseases, the important subject of genital tuberculosis receives a separate chapter. A great deal of care has been bestowed on the explanation of the mechanism in versions and flexions. The author is especially to be congratulated upon the successful way in which he has presented the difficult subject of ectopic gestation. Several minor subjects, such as kraurosis vulvæ have, on the other hand, received no mention whatsoever. The most important operations are mentioned in detail and the clearness of the text is still further enhanced by a number of excellent illustrations. The book is to be recommended as one of the best of the shorter treatises on gynecology.

*Die Technik der speciellen Therapie.* Ein Handbuch für die Praxis von DR. F. GUMPRECHT, Professor in Jena. Zweite Auflage. 8vo., 354 pages. Illustrated. Gustav Fischer. Jena. Seven marks.

For the general practitioner certain routine examinations in the realm of the specialist are indispensable. To gain command of the methods of examination of special regions and to be able to treat the common ailments to which such regions are subject, the greater number of practitioners must attend post-graduate courses. In such courses treatment of the affections of the nose and throat, the stomach and intestines, the

bladder, etc., is learned by actual work with the patient. The present volume serves the purposes, in large measure, of just this type of post-graduate instruction. It contains discussions, in brief, of the anatomy and physiology of a given region, and then describes the instruments used in the treatment of the more common diseases of the regions, with full detail as to the correct procedures. In addition it gives reasons why certain methods of treatment are advisable and discusses quite fully the *rationale* of a large number of technical applications.

An abbreviated list of the subjects treated is here given: Puncture and incision of the skin, blood-letting, transfusion, and vaccination; esophageal sounds and their uses, washing of stomach, feeding by esophageal tubes, electrical treatment of the stomach and intestines, massage of the intestines; treatment of the upper air passages, mouth, nose, pharynx and larynx; thoracentesis, drainage of chest and pericardium; abdominal puncture; lumbar puncture, and technical procedures for the genito-urinary tract.

The work is a valuable one for the student and the practitioners removed from the facilities of clinics and clinical instruction.

*Sixth Annual Report of the Board of Managers of Craig Colony at Sonysa, N. Y. To the State Board of Charities. 1899.*

THE report of this Board, of which Dr. Frederick Peterson is president, is of interest as it shows the development of one of the newest and most important branches of State charity. Since the opening of the Colony, February 1st, 1896, there have been received 504 epileptics, of whom 378 remain. During the past year 95 cases were admitted and 39 discharged. When the buildings now being erected are finished, the Colony will be able to care for 720 cases. There are already more than enough applicants to fill the additional beds.

All improvements during the last year have been made within the limits of the appropriations. Among the needs of the Colony for the coming year are dormitories and infirmaries, and for this purpose an appropriation of \$100,000 is asked. Among other appropriations asked for is \$4000 for scientific research. The death-rate for the past year was less than two per cent. The good results of treatment and life at the Colony have been more marked the past year than in previous years.

*The Nervous System of the Child. Its Growth and Health in Education.* By FRANCIS WARNER, M.D., Physician and Lecturer at the London Hospital. New York: The Macmillan Company.

THE impulse which was given by Preyer to the study of child-life has produced within the past five years a veritable avalanche of treatises on the various attributes of child-life. None has been more interesting than those devoted to child-psychology. While we have yet to see a presen-

tation of the child's development as comprehensive and as suggestive as that of Preyer, this volume presents a number of features that are specially commendable.

The author's standpoint, the child's relation to education and the school, is especially engaging, since so much is hoped for in education and often so little is realized. As a guide for teachers and parents who desire to observe their children closely and wish to correct faulty habits of work and encourage fruitful lines of activity, the present volume is to be warmly commended.

## BOOKS RECEIVED.

*The MEDICAL NEWS acknowledges the receipt of the following new publications. Reviews of those possessing special interest for the readers of the MEDICAL NEWS will shortly appear.*

THE SOUL OF MAN. By Dr. Paul Carus. Second edition. 12mo., 482 pages. Illustrated. Chicago. The Open Court Publishing Company.

THE IRRIGATION TREATMENT OF GONORRHEA. Its Local Complications and Sequelæ. By Dr. Ferd. C. Valentine. 8vo., 221 pages. Illustrated. New York. William Wood and Company. \$2.00.

VENEREAL DISEASES, THEIR COMPLICATIONS AND SEQUELÆ. By Dr. E. L. Keyes and Dr. C. H. Chetwood. 8vo., 356 pages. Illustrated. New York. William Wood and Company. \$2.75.

PROGRESSIVE MEDICINE. A Quarterly Digest of Advances, Discoveries and Improvements in the Medical and Surgical Sciences. Edited by Dr. Hobart Amory Hare. Vol. I. March, 1900. 8vo., 428 pages. Illustrated. Lea Brothers and Co., Philadelphia and New York.

THE ANATOMY OF THE BRAIN. A Text-Book for Medical Students. By Dr. Richard H. Whitehead. 8vo., 96 pages. Illustrated. F. A. Davis Co., Philadelphia. \$1.00.

INJURIES TO THE EYE IN THEIR MEDICO-LEGAL ASPECT. By Dr. S. Baudry. Demi 8vo. 161 pages. Illustrated. F. A. Davis Co., Philadelphia. \$1.00.

THE INTERNATIONAL MEDICAL ANNUAL AND PRACTITIONERS' INDEX. A Work of Reference for Medical Practitioners. 8vo., 747 pages. 1900. E. B. Treat & Co.

ELEMENTS OF CLINICAL BACTERIOLOGY FOR PHYSICIANS AND SURGEONS. By Dr. E. Levy and Dr. F. Klemperer. Second Enlarged and Revised Edition. 8vo., 441 pages. Illustrated. W. B. Saunders, Philadelphia. \$2.50.

ESSENTIALS OF SURGERY. By Dr. E. Martin. Saunders' Question-Compends, \$2. Seventh Edition, Revised and Enlarged. 342 pages. Illustrated. W. B. Saunders, Philadelphia. \$1.00.

PLEA FOR A SIMPLER LIFE AND FADS OF AN OLD PHYSICIAN. By Dr. G. S. Keith. Demi 8vo., 175 pages. The Macmillan Company, New York. \$1.25.

DISEASES OF THE GENITO-URINARY SYSTEM. A Thorough Treatise on Urinary and Sexual Surgery. By Dr. Eugene Fuller. 8vo., 774 pages. Illustrated. The Macmillan Company, New York.

TWENTIETH CENTURY PRACTICE. An International Encyclopedia of Modern Medical Science. Edited by Dr. T. L. Stedman. Vol. XIX. Malaria and Microorganisms. 8vo., 828 pages. Illustrated. William Wood and Company, New York.